

ANNUAL REPORT  
OF THE  
BOARD OF DIRECTORS  
AND  
MANAGEMENT

VOL.  
LXX CY199  
2002







JOURNAL  
of the  
ROYAL NAVAL MEDICAL SERVICE

www.elsevier.com/locate/jmb

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## Contents



- Captain Rick Bowen, ARMC, QALNS Director Rural Nursing Services and  
Member ex-Officio QALNS

1000

- Lights Out! Down Ward Hoising and Michael Carr during the Oregon War*  
By Scott Munro, Gary Scott and Richard Adams

- The
- Enfermeiros do Queen Alexandra's Royal Naval Nursing Service*
- 23

[illegible]

- Steven Winkler On Enormous Longevity**  
*On becoming America's oldest actor*

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

- Figure 1**

100

Age Group	Male (%)	Female (%)
18-24	10	10
25-34	15	15
35-44	20	20
45-54	25	25
55-64	30	30
65-74	35	35
75-84	40	40
85-94	45	45

- 100

**These cover:** *Songs of the Church*, *Miscellaneous*, & *New World Norway*. *Norway*

The Journal of the Royal Physical Medical Society is disseminated and indexed by the following services:

Health Star, Med Alert, CINAHL, CopeLink, Index Medicus, EMBASE/Excerpta Medica, Index Medicus, Research Alert, Scisearch



# Editorial

You will notice by the cover that the contents of the Journal has a decorative pattern flowing to its centre. The reason is that this year celebrates the centenary of Royal Photomicroscopy for Queen Alexandra's Royal Naval Nursing Service and it is a great privilege that I find myself as Director and Museum-in-Chief with the opportunity to write this editorial.

Papers in this edition include a detailed history of the late Helen Macdonald and in tracing the official recognition of naval nursing. A record of the Admiralty's establishment of QARNNS is repeated and photographs of the dedication of a memorial plaque and two, printed in the *Quarterly Bulletin* as they are also provided. An example of the experience and multiplicity of QARNNS capabilities is recorded in an article describing an exchange experience with the Royal Australian Navy.

To mark the centenary a number of events have been planned over the year provided by the planning of a new and the celebration of a plaque in the Garden of Remembrance in the Royal Hospital of Naval Medicine in this year. In May this Royal Photomicroscopy Association will be the guest of honour at a reception at the Goldsmiths Hall London. This will be attended by up to five hundred serving and retired members of QARNNS during which a book entitled "History of the Naval Service" will be launched. In the summer the QARNNS annual symposium will have the history as its theme which will prove to be both educational and enlightening. A sailing expedition in July/August will visit Lisbon and Gibraltar and in September a ship at Portsmouth Cathedral will be dedicated in our memory including an visit and is expected in the year of the ship. On 10 November

The Royal Photomicroscopy

Society will meet

a group about

which may

see

that is. Throughout the year a number of public talks will cover our history, contemporary work a range of articles on the February edition of Navy News.

The last one hundred years of Royal Patronage for QARNNS have undoubtedly seen monumental changes for the Service and the nursing profession. The numbers of personnel have fluctuated over the period with the largest numbers occurring during the two World Wars and in the 1960s, following the return of a young 1920. The Service has continued to keep ahead with the pace of development and continues to be the envy of many of our civilian colleagues. QARNNS has always met the changing requirements of the nursing profession and contributed to development wherever it has been needed. The education and training of nurses commenced in 1986 and we have been the only Service to introduce this role without any breaks in staff.

The last decade has seen much more joint activity with our sister Services. QARNNS have worked in the area with the Primary Command Recovery Ship (PCRS) and the RANM Surgical Team. In addition we have provided support for all of the major conflicts. The future is now one of rebuilding. Following the Strategic Defence Review we are now moving up to a new experiment in order to

modernise Primary Command Recovery Ships in addition to the Surgical Team. RFA HCG95 has just been ordered and will provide a unique medical facility for offshore medical care. The second PCRS is at the early stage of agreement and is expected to be in commission later this decade. The education of our personnel is now managed in a 16 Service team and following our successful ventures with the University of Portsmouth we have moved to a new era with the University of Central England in Birmingham.

The incorporation of QARNNS into the Royal Navy creates a Royal Navy liability for all of our nursing personnel whilst ensuring our unique identity within the Royal Naval Medical Service. QARNNS now stand as Ministry of Defence Hospital Units Medical Centre and Headquarters. We continue to prepare ourselves to provide the highest level of care to Royal Naval personnel in times of conflict whilst maintaining a driving force in our areas of influence in both primary and secondary care. I have no doubt that the pace of change will not slow and that there will be many opportunities ahead for our Service. The next six hundred years for QARNNS will I am sure be just as dynamic and significant as the last with our nursing personnel standing at the forefront of professional activities.

Mark Brown

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Number 164266-0095



Member of the Association of Service Newspapers



## History

# Light before Dawn: Naval Nursing and Medical Care during the Crimean War

Richard Hantsman, Mary Bruin and Deborah Holtum

*There would be the same true love story written to the devotion of the medical officers in fulfilling their obligations and in the brave sacrifice of that other nursing agency which has added a new, noble and a fresh glory to the annals of female heroism.*

*Report to the Royal Mail, Lord Palmerston. His was a copy of the Proceedings of the first Navy Committee Deputed to the East of the Nile in the East (1855-56) (p148)*

*Presented to both Houses of Parliament by command of Her Majesty (March 1857)*

The Royal Naval Nursing Service, which was founded in 1842, was honoured with its position only before Queen Alexandra became the Patroness in 1902. The subsequent history has been well recorded but less information is available covering the details which first led up to the official recognition of naval nursing.

The Crimean War (1853-56) which was fought against Russia, was the pivotal event that effected revolutionary change in the nursing and medical care of the British armed forces. Initiated by Florence Nightingale, the heroine of that war continues to be studied and for this reason the story of the origin of nursing in the army is well known. Florence Nightingale and her nurses are universally commemorated by the army in the manner the equally conspicuous part of women met out by the Admiralty should be recognized today in the persons who founded the Queen Alexandra's Royal Naval Nursing Service (QANNS). At the close of their service the war laurels, this third voluntary war agency is to be an appropriate award to its own staff role.

During this tragic military adventure, nursing officers, entering the costly final month on Liverpool supply vessel, the *Highflyer* had no business there.<sup>1</sup> Their companions were on the land and not on the sea to be remembered for

*Figures 1, 2 and 3 show the position of the places in the Bosphorus and the Crimean Peninsula that are named in this paper.*



Figure 1. Black Sea



Figure 2. Bosphorus

Dr R Hantsman<sup>1</sup> MRCPsych, Mary Bruin BA & Deborah Holtum.

<sup>1</sup> The Gazette of Naval and Maritime Forces, General Government of Newfoundland, Address for Correspondence, Dr R Hantsman, Assistant Commander General Hospital, St John's, NL A1B 3X6.



Figure 1. Crimea

operation of the war in which they were ordered to fight. The hospital did not wish to see a Russian fleet in the Mediterranean, hence the desire to ensure their Black Sea fleet and dispatch the port of Sevastopol. But was it unreasonable that the Crimean War was transferred between the first Afghan War (1839) and the second Afghan War (1879). The British had every wish to collect a military tribute and to denigrate the Russian fleet from entering India through the Red Sea.

Lord Raglan, who commanded the army was against the dispatch of troops to the Crimean Peninsula. Unaware of the number and disposition of the opposing Russian troops he was warned by Sir George Brown who commanded the Light Division, that the Duke of Wellington, who had gone to India, would not have entered into such a campaign. Unfortunately because an army cannot move home having achieved nothing he also told that if England would not do it, the government was to insist that they would appoint another to Raglan might as well command himself. Lord Raglan's intention did not permit him being held responsible even after his death during the war for the disaster that followed. Having the Crimea with a loose before Christmas attack, our troops that is completely untrained, untrained, and in consequence had to face a better water for which they were hardly equipped. This was despite the subsequent claim of the British Government that large quantities of warm clothing had been ordered on August 1854. A month before the landing on the Crimean Peninsula.

The Russian forces departed in October before with 200,000 of warm clothing for the troops a rain wind in those days, only to be back along with 35 other ships and guns too, of late in a

tempestuous storm off Balaklava on 14 November 1854.<sup>11</sup>

What was the reason for the 'unreasonable' standard of clothing that existed at that time to the British armed forces? Why, in contrast, were the French and Russian military hospitals staffed with trained and dedicated British nurses?

#### Nursing in the "Dark Ages"

The Declaration of the Memorandum in 1846, actually ended the contribution of the military and the concept to the care of the sick and the aged in that country. Only the title of 'Nurse' remained around in all other parts. It was, after the, original notion that the standard of nursing in Catholic and Protestant convents degraded.

In Vienna de Paul (1851-1860) by ensuring the use from the convent and bringing the Society of Charity, entered the contribution of devoted nursing care in French hospitals. His attempt was followed by the founding of Catholic nursing associations in England.

In contrast, Lord Gamp and Sir George Paget, national characters, participated in (Dorland's, Martin Chuzzlewit's) were caricatures representing those who might at that time lead the sick in Victorian Protestant England. Sir George Paget was recommended that 'Bartholomew's' advised the other associated Lord Gamp on his arrival for eight days that the only thing could be made more considerably if also took the patient's pillow? Not all nurses were as bad as those two portrayed by Dickens and, in that dilemma, it was widely recognized that beer and tea beverages were far more delectable than water. As food partly for that reason, beer was generously provided especially by the working class, at that time. However, Nightingale allowed her nurse in the Crimea, that one part of the problem to have been commonly drunk by patients for health. For supper they were allowed half a pint of porter or a glass of wine or beer or brandy. It is constant attendance on most of soldiers during the war, whether could be obtained? At that time patient for support had an alcohol system between 85 and 100% approaching that of wine. There is no reason to believe that any naval nurse who engaged a 'tippie' would have been treated with less generosity than nurses serving in the army. The experience got in by Thomas Hospital for some porter, beer, champagne and brandy, not forgetting the rum, - appear to be more than adequate to maintain a civilized nursing and medical staff.

An English hospital in the 19th century seemed to poor nursing students by seeing that providing a better idea of women would cost too much money and as for cost, the doctors, who practised much medicine of their would be, as disappointed as expecting women would undertake the work.<sup>1</sup> When Florence Nightingale announced early on her life that she wished to nurse at Nightingale Hospital, her medical patients thought the suggestion to be worthy to be a better man, and they were not the least the work.<sup>2</sup>

Elizabeth Davis, who served with the army in the Crimea, had experienced both domestic service and nursing, and preferred the former. But was the only professional nurse not associated with a religious order to record her nursing experiences, which were in places critical of Florence Nightingale, as well as some of her own nursing colleagues.<sup>3</sup> In Richard Cook, the "wildcat" biographer of Florence Nightingale, describes her story, which is the modern reader has a way of such about it, as the work of an extremely uneducated female and prejudiced woman, which was not to be trusted.<sup>4</sup>

It was agreed early a background that a few women, especially the widows or wives of women, found employment in rural hospitals or on board ship before the Crimean War.<sup>5</sup>

#### Nursing Roles in Protestant Countries

The nursing profession and even failed between Catholics and Protestants continued in the century well into the 19th century. This meant that only on rare occasions were Protestants even aware that both as the Continent of Europe and as Ireland a Catholic model of nursing was available for them to imitate. It was only through the nurses who visited Catholic hospitals or in the hospitals that Protestants slowly became aware of the latter system.

The first extensive steps towards nursing reform in England took place in the beginning of the 19th century, well before the Crimean War. One of the few persons who had visited Catholic hospitals in the Continent was the physician Dr Robert Conch (1781-1856). As a boy Dr Conch had been present at Yarmouth Naval Hospital where it was visited by Nelson after the Battle of Copenhagen (1801), in which Nelson had lost a blind eye. After seeing a sailor who had lost his arm, he remembered Nelson telling the famous comment "Well, Jack, don't you and I get quoted for information about my lower limbs!"<sup>6</sup> The

survivor by Dr Conch in extended complex Portuguese nurse was the country was, as for what early religious associations.

After the Battle for Quebec (1759) the ill and wounded French troops, admitted to Catholic hospitals in the town were treated by the quality of the care they received. The contrast between their "astonishing ignorance and order" treatment was compared with their own "tolerant organized hospital."<sup>7</sup> Nothing at that time changed, and 120 years later in the Crimean War an identical disparity in the level of nursing care available to French and British troops was again observed. The case to the large physician W. H. Russell. His report, written in public outcry and the severe disposal of nurses to British military and naval hospitals in the war zone. The purpose of the essay under the direction Florence Nightingale has caused British historians. In his comparison the history of the moral issues in the Crimean War is little known, and what details that are available are centered in the treatment of the war.

#### The Institution of Nursing Sisters

When told Dr Conch visited Elizabeth Fry (1784-1845) the Quaker prison reformer and Florence Nightingale (1820-1910) visited sister Constance, both visited Catholic hospitals. They were made well aware of the excellent service offered by the Catholic nursing order, the Sisters of Charity. Elizabeth Fry mentioned the tradition of the Catholic women with the "Habit of Love, Purity and the endurance of two years". In her recently discovered diary Florence Nightingale describes visits in 1850 to the Hospital St Vincent de Paul in Richmond. She noted the care given to the 1000 patients by the 3000 women as "disciplined, quietness, kindness, devoted". The time for nursing orders in Protestant hospitals had not arrived.

In 1830 a Protestant organization that trained nurses was established in Germany in Germany. The founder Fanny Placher (1800-1866) was a close friend of Elizabeth Fry who had helped her to enter both prison and nursing reform. Like in the Crimean War nurses who had been trained by well rewarded from Massachusetts eventually used for British troops.<sup>8</sup> After Florence Nightingale had arrived in the Crimea, Constance Fanny Placher's appeal was offered for the services of their nursing order. She declared because she had no room for them and only their "poor English".

In 1860 Elizabeth Fry using Ransworth as a model established an infirmary in London – the Protestant Sisters of Charity. After objections by Queen Victoria, then Princess, and the Bishop of London, the name was changed to the 'Institution of Nursing Sisters'. Candidates were to nurse at Elizabeth Fry's Institution until 1870 and were, in the main, women respectable and known domestic workers selected by both physicians and voluntary committees. After apprenticeship they received their monthly hospital training which was given first in the London and later in Guy's or St Thomas's Hospitals. In order to make the Institution financially viable, the great majority of the trained nurses worked with wealthy families, although a few did subsequently enter domestic and hospital nursing.<sup>1</sup> The provision of Royal Passage to Elizabeth Fry's Institution began a tradition of such passage which continues to the nursing profession, it is the continuity of this Royal Passage which is being celebrated in the Q&A/2002 this year.

Following in the footsteps of Mrs Fry's Institution members, high church Anglican sisterhoods were established which, in the eyes of the public, were seen to have different from Catholic institutions. For a short time these sisterhoods recruited by Florence Nightingale for the Crimea but took over the nursing at King's College, Chelsea Cross and University College Hospital.<sup>2</sup>

Elizabeth Fry and her Institution of Nursing Sisters were criticised for concentrating on private patients and ignoring the plight of those in hospital. Her discussion in 1860 her nurses the right to refuse hospital nursing stated that she was this, in doing the problem encountered by the sister Elizabeth Ashurst in 1860 was Edward Perry FRCS who, as suggested as others nursing in the Royal Naval Hospital, Haslar.

Edward Perry, a relative of Elizabeth Fry,<sup>3</sup> had been closely involved with her efforts and those of the Rev. Thomas in private and hospital and naval services with military hospitals. Having met Elizabeth Fry at the house of her son in 1854, he and two others were selected as clerics on voluntary basis for the Crimean campaign.<sup>4</sup> In 1861 seven years after the founding of the Institution of Nursing Sisters, by Mrs Fry, Perry wrote that in four respectable Christian women to emerge hospital nursing under the disapproval of Ransworth, sister in the German Hospital in Dublin, London or in Ransworth. They would take no more but

would agree to work in Ransworth at least two years. Opposed by the poor masters of Christian charity, they would accept 'no salary or other remuneration beyond a diet and comfortable maintenance. Charges a respectable citizen, not too warmly welcomed'. They proved that working conditions especially the appearance of domestic and nursing Sisters had to improve before nursing in hospitals became a desirable career for respectable Protestant women in this country.

#### The Response of the Army in the Crimean War (1854-6)

The extraordinary reputation which My Sister Barbara Martineau in 1861 amongst the disciples of Florence Nightingale and her party of nurses in the Crimea War is commonly described in two sections to public regard. Elements of the Crimea do not commonly exist in public imagination with the spread of learning. The likely truth is more interesting. Within days of the news of the first conditions in the hospitals in the East having reached England, a number of wealthy English ladies were making private arrangements to fund and dispatch parties of nurses and doctors to the war. 'In no distant whatever to the country'.<sup>5,6</sup> Florence Nightingale had herself agreed to lead one such party of four nurses. The administrative expenses that would have been created by such movement independent and unaffiliated groups hitherto in the domain of army and navy hospitals was a most likely scenario in the early historical that this public aspect.<sup>7</sup>

When Florence Nightingale was officially called upon to lead a party of nurses to the war she realised that in family public opinion she had to include a balance of Catholics and Protestant nurses, the former to care for the 80% of British troops who were mainly Catholic in faith. Recruitment of the necessary nurses from the large pool of Catholic nurses available was easy. In order to present a neutral balance to a suspicious public, she initially approached Mrs. Fry's Institution of Nursing Sisters as an attempt to recruit respectable, trained Protestant nurses. Apart from the high church Anglican sisterhoods which were related with great suspicion by the public, this was the only organisation in that time with available nurses and acceptable Protestant credentials.

The nursing services in Haslar and Chalk reported in 1861 that Florence Nightingale was refused help. The Agents of Mrs Fry must have

been for the same thing about... It was even suggested at the time that Fry had been dead some years; that that was a nice little discovery... a Quaker and one of the Peace Society, that with a week could even have been conscripted by him.<sup>12</sup> The subsequent removal of the Quakers caring for the injured in war proved the view of the Fellowship Society of Friends to be false. Florence Nightingale was explicitly disapproved by her apparent refusal because

He is extremely desirous to include all classes of opinion in trying to do all benevolence; different might work together in a common brotherhood of love to God and man.<sup>13</sup> There may also have been a more personal reason for his disapproval of being opposed by Elizabeth Fry's Institution. The controversy among Quakers in North London upon the Florence Nightingale in a young woman and Elizabeth Fry – who was an ever present supporter with Florence Nightingale in the years that followed. Elizabeth Fry was also involved with introducing Florence Nightingale to Kansas, where she worked for a few months.<sup>14</sup> Certainly Florence Nightingale could enough about the Institution of Nursing Service to support them financially with a donation of £5 in 1841.<sup>15</sup>

In contrast to Harvey and David, Sarah Taylor reports that women from Miss Fry's Institution accompanied Florence Nightingale when she left London in 21st October 1854. In fact the opinion of both historians are in part correct. The Inquiry Commission running the Institution correctly realised that in their houses had been given a right to decide the type of nursing work they would undertake; they could not order them to go. The Institution therefore responded immediately not by a compulsory refusal, but by asking them could be volunteers, who would receive their jobs back at the end of the war as owners of a volunteer reference. The women returned to join Florence Nightingale and of their own volition Anne Wells, who in the war who joined the party that was later recruited for the same. The women are now asked to volunteers had not had previously in place, thinking that were well away of the rough, unpleasant conditions they would have in a hospital in the country. It alone showed, likely that as well as the war came the nurses recruited by the army called the two who refused from the Army doctors in contrast to the spite that which were called 'light company'.<sup>16</sup> They would not even show leaders in the night of night, taking up that they found on their pockets. Also living on the Congo

For weeks had an extremely unpleasant reputation and that was before he visited the company of the food in their diet. To add to their discomfort, mosquitoes were so often heard.<sup>17</sup>

The party that eventually accompanied Miss Nightingale consisted of 100 Catholic nursing sisters, 14 High Anglican nursing sisters and 14 temporal nurses. These last came from the International Nursing Sisters, were described as of no particular religious values, the nursing of Red Cross to be noted.<sup>18</sup> – an opinion that adds further testimony to the inadequacy of the hospital staff of the era. The patients pay offered 100 to 150 shillings a week (70 shillings for 100) would have attracted rather applicants.<sup>19</sup> It was only later that nurses from the hospital were recruited to join Florence Nightingale, and they received 400 to 500 per annum.<sup>20</sup> A handsome one from the £100 to £25 per annum they had previously earned.<sup>21</sup> One reason that the highest pay nurses recruited by the army would have received would be the same amount as their value.

The contribution of the Catholic and Protestant nurses working together in the war with a common goal, did much to dispel the hostility between the two denominations, and resulted in a voluntary collaboration of mutual sympathy.

The only surviving traces of the humanitarian and unselfish nature of all made for the same time<sup>22</sup> that was used to those Christian War nurses in the short warlike clock. They should be valued by those who were today as a living memorial to the human spirit and the best values that that time of the war or others the time of that time carrying a memory of life or war. No doubt, that nurses lost their lives although all on numerous occasions. However, they were medical officers, dead in the Congo campaign, none of them from war injuries.

The uniforms for the first time consisted of a cap with full placed under a striped top or ribbon of standing out, worn under a black, open button, a grey cloak, and a broad band worn across the breast with 'Thompson's Hospital' worn on it in large bright blue letters.<sup>23</sup> One can imagine it, proved it impossible in the uniforms supplied for the army nurses.<sup>24</sup> Mrs. Macdonald and the doctor had a great of a slightly excessive part, who appears in driving, rather badly.<sup>25</sup>

#### The Response of the Nurse in the Congo War

The great hospital at Thaps, 12 miles to the North of Congo (now distant) was

established in December 1913 on land being ground by the sea. Because the Kransburg Block Line Run was intended to defend the harbour in Sevastopol, the exposed sea beach was not good place and the number of wounded sailors and seamen severely increased was decided less than expected. From November several small boats 1914 when the bombardments of Sevastopol in which both the Marine, and the Naval Hospital fought on land, commenced. Unhappily the Crimean War resembled with a pandemic of cholera. Mortality on both sides was high but the war was not badly affected. Russian good day and the effects of a fatal wound were then made up for any deficit of war wounds.

Unlike the large army hospitals, Thompson was on the European side of the Bosphorus, locally a small & temporary hospital but its scope was later enlarged as a base hospital to receive the worst cases of infection and injury as they were evacuated from the Crimean Front-line.

The only serious outcome of the war on the Crimean War is their obvious responsibility for shortcomings in the medical evacuation of both army and navy personnel to the base hospitals on both sides of the Bosphorus. Rear Admiral Bower the senior naval officer died in June 1916 before he could be recalled. Having suffered from diarrhoea he was treated with cholera and died 22 hours later.<sup>12</sup> He had been well thought of by many seamen. Bower the chief who visited the Crimean line from a very short period and expedition – though very little like – rather rough and uncomfortable – by report generally liked.<sup>13</sup> Captain Augustus Rappell of the ship *Eden* of *Eden*, who later commanded the Naval Hospital before on land and ended his career as Admiral of the Fleet described him as ‘a son of the old school’. When Rappell commented that Admiral Bower had not had breakfast the Admiral replied ‘I am an old fire-breather and shatter breakfast with me for under the table!’<sup>14</sup>

Nothing would outweigh the risk and severely wounded who were often lying exposed and suffered on deck took up to 14 days to reach the Bosphorus from Crimea. A winter whether public or worse could cover the distance in 10 hours. Bower stated required men might spend up to a further week on ships waiting near force the army hospital at Bower or in the navy hospital at Thessalon. The Marines were particularly unhappy not being allowed to land until it was decided if they were soldiers or sailors! As with other military and

political leaders recognised after the Crimean war Admiral Bower's primary administrative system as have been preserved as the was demonstrated in a hospitalised medical system, breakdown under the Battle of Waterloo in 1815. In addition there is much with the Navy Medical War used on which was greatly responsible for the inclusion of disease related by the Allies in the early years of the Second World War. Failures of 1900 and 1901 in England are mentioned as major warlike.

In the Crimea the navy had to cope with three casualties and never faced the crisis that. From the start overwhelmed the medical services of the navy. They approximately 1000 beds in Thessalon, most in comparison with the civilian, French Hospital in Salonica which could ‘tend’ 1000 patients and 1000 patients. In present Salonica’s closely packed beds held at times 3-1000 patients – the ground members being very variable and were crowded to stretch two and a half miles. The concept of economy of space (disgusting changes and more efficient was proved necessary than 100 years before it was introduced by the navy plan. The overcrowded army hospitals which were structurally and hygienically unsatisfactory were simply unmanageable. It was common knowledge, well before the Crimean War that overcrowded poor ventilation, unsafety in disposal of waste safety lack of personnel hygiene and failure to use disinfectants widely would all contribute to the spread of infection.<sup>15</sup> Florence Nightingale and the medical officers would have been well aware of the problem outcome in which their patients were placed and would not have been surprised by the outbreak of cholera mortality in Salonica. Nobody knew of all Florence Nightingale should now be held responsible, for either the situation or its consequences.

#### The Sanitary Commission

After, if the unacceptable public health problems during the armed forces the Government seriously dispatched the Sanitary Commission.<sup>16</sup> It started work in Salonica the afternoon of its arrival in March 1915. Led by Dr Nicholson a renowned son of Dr Green, a sanitary engineer and three sanitary inspectors. Recalled recently from Liverpool. All were experts in urban sanitation. The team must with great energy not only inspecting, but also advising and then after its return to inspecting in one whether their advice had been taken. Sadly Dr Green was killed by his brother in a

storing munition, and the place was taken by a 25th Bde.<sup>10</sup>

The majority of the bulk can be measured by the necessity to remove 400 tons of dirt from the streets of the Newark and General Hospital at Humber prior to the installation of a flushing system. An approached pipe to the hospital had them on the construction to carry water from a spring some four miles away. Two tons of dirt were also removed from the vicinity of the hospital at Humber, and 24 dead animals were buried.<sup>11</sup>

The medical authorities, as later claimed in their defence by the fact that the senior army medical officer may well have previously recommended many of the changes subsequently introduced by the Sanitary Commission. The playing down of any shortcomings of the medical staff is substantiated by a comment by the senior medical officer of the Black Sea fleet, Dr David Dunn, that "nothing would was suggested in September, October or November 1914 but when the Florence Nightingale put the words of having been dignified and stressed, for there is no great harm in this."<sup>12</sup>

The fundamental difference between the misbehaviour of the medical staff of both the army and navy, and the success of the Sanitary Commission was the taking of the latter to implement these demands rapidly. This contrasted with the complete lack of resources, power of army and navy medical officers, who could rarely recognize field and recommended change to an unimproved senior officer often of higher social status than themselves.<sup>13</sup>

The credits achieved by the Sanitary Commission depended not only on its overriding power but also on the fact that it stayed on site for over a year. Unlike the doctors and nurses they had no official responsibilities and could spend the desperate phase of the pandemic around them and concentrate solely on the creation of all the sanitary desiderata. During this time Dr Nuttall had formed a working professional relationship with Florence Nightingale and it would be by him quoted for later interest in insurance and hospital groups.

Florence Nightingale later told Lord Melfort that it was the Sanitary Commission that "saved the British Army". This may be arguable but it is probable that the Commission was not only responsible for ameliorating living conditions, which spread under the influence of Florence Nightingale and medical practice but also for introducing "measures" of a total

sanction of the medical services of the armed forces. The influence of the Sanitary Commission layered on Victory at the critical battle of El Alamein. Despite the Second World War it was before us perhaps the superior camp hygiene of the British Army, when compared with their German opponents. At the time of the battle the German commander, Rommel was ill with dysentery.<sup>14</sup>

At its birth, and apart from the Blackbirds before, the war also introduced card games. Indeed when the weather permitted poker went by Lord Cardigan in the charge of the Light Brigade and again during I conducted by Lord Raglan, the commander of the British Army.<sup>15</sup> Finally the British Military government was copied from the one worn by the Russian troops.

In their words, the naval authorities strongly recognized the importance of the Sanitary Commission and sought their full involvement. "The Admiralty decided it expedient to put the Commission in communication with the naval authorities in the Black Sea".<sup>16</sup>

#### Therapia Hospital

Therapia Hospital, previously an old inn,<sup>17</sup> (spoiled by the British) was a wooden structure two or three stories high set on a large walled garden with the hospital water taps on the ground floor.<sup>18</sup> During the first few weeks it was necessary for patients to travel from the ship, walk three miles land, through Istanbul and railway. The food and bedclothes were to be mailed with the name of the ship and returned when the patient recovered.

In January 1916 supplies were reported from Malta and the hospital was thereafter well equipped for the expected demand. When supplies, however, was ordered it could be received by foreign office messenger two days, after the cable was sent to London. As well as venereal, the hospital treated cases of dysentery (which was a "chronic" disposition) injury and even carcinoma. Inevitably venereal disease, fever, and malaria.<sup>19</sup> Despite the fact that the weather at Therapia was dry and not too hot patients (patients) with lung disease had poorly being transferred to Malta as soon as possible.<sup>20</sup> Medical officers were impressed that, despite the appalling weather and exposure the constant lighting on land did not suffer as network of pulmonary tuberculosis, though it did not to be treated in great part, by fresh living conditions.<sup>21</sup> (The final confirmation that the "infected facilities" was the constant exposure

of anti-dysentery" and a "small ward" (1885).

Although the first drainage pipes supplied with perforated "spacers" (see medical museum) might have been once useful if a plastic spreader system brought the faecal mounds too great to be removed, unless it proved probable that "backstop"

Thames Hospital were first suggested by the Sanitary Commission in the spring of 1845, clearly that the main - area of the building was, largely confined to the limits of its poor structural condition (overcrowding, inadequate drainage and open drains attached to the wards) it was estimated that two-thirds of the typhoid cases had originated within the building. Every provision throughout the hospital and, beside the patients' doors of the main female wards were attached.

By the winter of 1845-6 the seriously ill patients were being taken to Thames Hospital in April 1856 reported that "The authorities of the Commission as regards the hospital had been substantially carried out. The policy as to the basement of the building had been cleared, and more rooms substituted for those in the upper and middle floors. It was in excellent sanitary condition in the as regards cleanliness and ventilation and there was abundant space for the bed."

As the need increased, the medical staff grew from one assistant, supplied to two surgeons and three assistants. The situation given to the hospital by the Deputy Medical Inspector of the Fleet Sir David Ogle and the Deputy Inspector at Naval Hospitals and Surgeon in Charge Dr Davidson who was accompanied by his wife "was displaying the hospital being described as 'the apple of Dr Davidson's eye'". Dr John Davidson was an experienced surgeon, his had been appointed Assistant Surgeon in 1829 and served for the next six years as deputy of the first leader. Promoted to Surgeon in 1846, he indicated various duties at the Cape of Good Hope on previous service as Assistant Surgeon Hospital and on various ships. He was appointed to the temporary hospital in Thames in January



Aerial photograph of the original Thames Hospital, showing the main building and the surrounding area. The building is a large, multi-story structure with a central entrance and several wings. The surrounding area appears to be a mix of open space and other buildings.

Department of  
Sanitary Buildings in  
Administration

1854 and promoted Deputy Inspector in March 1855.

The initial medical staff were considered to be of high caliber by both their patients, and colleagues. Present in the early hospital in Kentish town males north east of London who studied with them were sent to Harwell in the "Hospital of Convalescence" some males made of Thames where they were treated by the staff of the naval hospital. One of the surgeons of the naval hospital Thames, needed them all though their officers, since it was necessary officers did be sent from his own patients duties to their families. He was not only physician, but as their afterwards expressed it, "father and brother". His patients were several weeks in progress. Hence can they keep the healthy individuals and patients which they received from their placement in there, we noted found friends in a foreign land.

The ladies belonging to the naval hospital also came forward with voluntary assistance in the case of

disease. One who had herself risen from a bed of sickness took her turn to watch at night by the bedside of those who were struggling to live."

Dr Patrick Wilson, a young army surgeon stationed at the military hospital at Kentish town again and served in a hotel near Thames during his early service. He served his early years being elected President of the Royal College of Surgeons of Edinburgh. He thought the naval medical officers of Thames, "entirely superior in point of scientific training and education to those we have at Chelsea (Glasgow)". Regarding this education the matter he visited the naval hospital as a member of occasion between April 1846 and 17th 1850. He described the educational grounds as "partly laid out in the close range but and extensive style and partly laid a very much neglected garden's park on a very steep hill side. He thought it almost to see patients convalescent from fever scrambling about among the bushes, the one out on the lawn it is half the story."

Later the Indian's Palace, next to the original hospital was incorporated into the hospital



The patients could thus be divided, with the understanding in the Prison Hospital visitors Officers were unacquainted and arrived without the problems that occurred in the Home Hospital.<sup>11</sup> As the main task as a copy transport vessel was made available to receive men and materials from other being conveyed to Moku and from there if necessary to the United Kingdom.

A number of other names under Mary Stanley, mainly at Thorpe, to be posted was asked in a party of several names was extremely suspected, but in some but in some with the boundary in the novel hospital. There was information which one of the letters accompanying the professional name was contained in them would have been the link, where health would have pushed them to undertake work before.

The Protestant afternoon service on Sunday which then they were attended was held in one of the wards of the novel hospital despite adequate ventilation, the small and dampness were seriously making it a real concern there the small being caused by the number of cases of infection; they observed that every case and attention was shown to the patients. During these very short periods arranged for a movement to be placed in the final period of the hospital.

Dr Peter Percival, a civilian doctor, was especially impressed by the Mary's adoption of the French system of medical care taking. The clinical observations, data and perceptions for independent were somewhat clear of paper, which could be carried and referred to as well enough. The French army system included details to fairly considerable degrees the surgery in the hospital having to rely on the military.

Lady Stanley whose husband was involved in commercial negotiations with the Turkish Government, visited Thorpe Hospital on November 1891. The first day I visited the hospital there were men lying there very badly wounded and under nursing was speaking to my one only you can be the last paid face as only lay on his back, but on the point soon found a part of a language learned how much they had suffered. Others who were better, looked up with pleasure at

English men. One or two walked my Grandfather. Now I could not stand a word for the last few minutes and used at one of the windows, saying my own. Nothing could look closer and nearer than the news of little boys. Several each of them was a small little, dressed with a white cloth, on which stood a fishy and Pigeon head, the medical staff, and perhaps the words and some other little women belonging to the patient. It was really quite touching to see these thankfulness for all that was done for them, and how well they knew their suffering, as far from home and kindred. We were afterwards to walk in the garden, a large and formal one, so long straight walks crisscrossed with rows of fine orange and lemon trees in full bearing. On many benches there and there were seated the convalescents, enjoying the fresh air. Another visitor, Lady Alice Blacklock<sup>12</sup> described the hospital as "beautifully situated and" in character, under the care and supervision of Mrs. Mackenzie.

Even before the arrival of the French nurses, the Rev. Osborne, on a some official inspection, made a happy visit to Thorpe Hospital. It is worth for it is not quite large enough for its purpose. Stanley could describe the cleanliness, comfort and order, which appeared in general.

I satisfied myself that the intention of those who are employed in the Mary in the East, would be made an impression, that in the event of sickness or wounds they will be, well cared for in every respect. He visited the patients

himself. I will only add what regard in the Naval Hospital. But it was in its management and general economy the one English thing, it was properly conducted in the first.

He did not speak well of the conditions about the beds, the benches and an old Turkish line of timber they contained in the Goddard House which were used for miscellaneous patients. One floating military belonging to the navy will also mentioned there and was said to be "irrevocably combined." This remark was by the Mary were largely ordered by the Secretary Commission<sup>13</sup> and it is well known that the Rev. Osborne had no mind when he made his advice to continue. This poor management appears to have



Figure 5. Left: John and Al Green (1891) JMS. Al made that of his research in the paper Hospital on 21 June 1931.

from the result of the survey and the way a staff responsibility for donor maintenance. The highest responsibility for donor lay with Admiral Gray, senior naval officer in the Kingdom, who responded to the chairman of the Sanitary Committee the same day stating that he also wished to absorb the bulk of the cost of donor-based facilities. The attending events were rapidly closed down.

#### The Working Staff in Thorpe Hospital

From the arrival of the pairs of nurses from Glasgow in June by 1850 onwards, at Thorpe Hospital was inadequately protected by other Marine men, some not speaking English or naval ratings recruited from these ships, the latter were often recalled to duty as they were needed.

Dr Davidson became frustrated by his failure to meet the needs of the hospital as when he felt more acceptable. Finally in November 1854 when Admiral Brown told him in front of subordinates and peers, that he could not let him, Dr Davidson told his William Ramsay Medical Director General that if appointments were not made he wished to be recalled to England. His attitude contrasted with that of some of the army medical staff at Brompton Hospital who were satisfied to be engaged in important work, that is essential state projects.<sup>14</sup> Dr Davidson, although himself lacking the authority was prepared to place his job at risk as an attempt to achieve the improvements he felt were necessary. However, the Thorpe Hospital and the previous subsequently failed there, the did not work. The arrival a few months later of both the party of female nurses and the Sanitary Committee ensured the speedy implementation of any changes that Dr Davidson was seeking.

Also in November 1854 the Admiralty, perhaps as worried as the Navy that patients of hospitals for well-protected diseases and diseases would demand attention in their hospitals, realised that the Navy would also have, to respond to the public, military. The responsibility of finding a leader for their own medical staff to Mr. Campbell, one of the Staff of Admiralty, who was assisted by his wife. He sought the services of Mrs. Mackenzie to lead the group.



Jane S. Eliza Mackenzie  
by G. C. S. S.

The number of nurses who accompanied the ship were taken by Mrs. Lindsay, Mrs. Vigney (the nurse in charge of various ships) and Mrs. Harriet went out to the naval party. Mrs. Mary Fildes, the granddaughter of Sir T. Mackenzie, a well-known politician and naval reformer,<sup>15</sup> took over when Mrs. Mackenzie was recalled home. Mrs. Mackenzie stated she was also accompanied by five professional nurses. In that case, one would not think about these women, then there is any accompanying domestic servants. The Sanitary Committee<sup>16</sup> reported a total of two nurses but it is uncertain if this figure included Mrs. Mackenzie herself as a lady nurse with sailors and boats. Regarding the whole evidence, it is probable the group consisted of Mrs. Mackenzie, three lady nurses and five professional nurses.

Even after the arrival of the female nurses, males continued to serve in the hospital. Could not be more desired. Dr Davidson advised you will not see that three female nurses do not separate the male nurses.<sup>17</sup> At first the appointment was honorary against his and his lady, however, as the part of the nursing staff. But when they realised that this was means of the rules of service, as the called them, and had no intention of increasing on their male personnel they warmly welcomed her help and service.<sup>18</sup>

#### Mrs. Mackenzie - the "Nightmare of Thorpe"

The Reverend John Mackenzie, the younger son of a Farmer, was a pastor of the Free Church of Scotland. His wife Elizabeth (Baker) who was born in Glasgow on 1 July 1816, was the second daughter of Dr Thomas Baker, who had participated in founding the church.<sup>19</sup> After the birth of Ada in September 1839 they had nine children, four of boys. When William Mackenzie declared their will of help. While waiting, Mrs. Mackenzie had attended a little nursing experience in the Midland and St. Thomas's Hospital for Cancer, which had a reputation as a successful operation to try the nerve,<sup>20</sup> which included working in a surgical ward.

an atmosphere which inspired rather than oppressed." Against such Scottish pride the statement "Why should this poor man suffer when if they would only use Denison and Maclean's car [Edinburgh) for over 150 years) difficulties, all his energy would be devoted." She realized that the United States was an amazingly hospital management rather than nursing and in the end of her short training "the progress of Midwestern hospitals and its quality."<sup>14</sup>

The Chinese War was the first in which anesthesia was used by the Army although it was up to you until the experience was long. The career began in 1904 and to sleep but in many cases they became a tedious and difficult task. Half an hour and even an hour has elapsed before any influence could be produced upon the patient and even then difficulty was sometimes experienced in keeping up the state of unconsciousness and the completion of the operation had often followed as one or any of the cases.<sup>15</sup>

Mrs. Maclean was not unusually famous about becoming the Miss Nightingale of Thorpe. She expressed her despair in letters to her sister. "It is so difficult an undertaking for me with such responsibility as the Admiralty and John as my supporters, with no pleasure in it. Also the Admiralty wish to make the thing (female nursing) general throughout their hospitals if it is successful at Thorpe. This responsibility is truly awful."

Mrs. Maclean proved a new choice offering a blend of pleasantness efficiency and tact. She succeeded in keeping such a lot of good, respectable women with international reputations and looking down in order and convincing their most violent nays and demands from Dr. Davidson who would think nothing of throwing the whole thing sky high and saying it was a failure.<sup>16</sup>

The party, after collecting at Marcellus, had a very stormy passage with only one candle in light three days. After their arrival on the 10th January 1870 the first task was to dry a stonemason's building of 14 beds by building the lower part by glass from kitchen fire. Dr. Davidson wanted the nurses to continue with the laundry but "they object as not yet willing. They are rather superstitious of people at home." Within a month was completed that Midway women wanted by two months, would carry out their duties. "Early then expressed by Dr. Dore that their enthusiasm would be short lived were not

epithet. He admitted "We are certainly better than our sister."<sup>17</sup>

At first, despite the cold, Mrs. Maclean slept in a large industrial room with six other women. One here did sleep had a room in the cellars, for her husband and herself. Not surprisingly she described her first six months in Thorpe as "a painful memory."<sup>18</sup>

The duties of Mrs. Maclean and her staff included a large amount of real housekeeping, seeing that the patients, many nursing and housekeepers, were housed, the beds were dry and warm and above all that the patients were appropriately fed. The work would mean a half hourly conference made with friends. As Dr. Dore described their work: Mrs. Maclean and her staff are doing admirable service, smoothing the pillows and washing the linings, as only women can do. "They had no problems with either their moral or economic position in the women servants. As a woman and mother they, on the contrary of all things in detail with, and I believe by their conduct to which, has certainly by order."<sup>19</sup>

A major problem was to facilitate the release of criminal hospital stores through a series of service and hope - *The Duke of Devon, The Duke of Devon, Elizabeth Dore* and Mrs. Maclean's experience this battle in the same manner - by directly approaching "I persuaded the workmen and their helping themselves in London that problem was first overcome by the most rigid Florence Nightingale who to release stores and at the same time secure treatment required two medical signatures from a busy medical staff."<sup>20</sup>

We get a description of the harrowing conditions of these famous food from a comment made by an officer to Lady Herby about Mrs. Maclean: "She had been left one night after an action in a kind of round room, home with about 30 wounded men, whom the surgeon had been obliged to leave, in order to attend to others. She had but a small quantity of bread and knew that weakened by loss of blood, the only chance of his which the poor fellow had, was being kept up until the return of the surgeons on the morning. All while the house lady worked hard by the light of a single candle. Many died around her but she kept on uncomplainingly and died on 12. There she could not save doubters, and thinking her." The much admired competence of Dr. John Hall the senior army medical officer, not to his obligations for "sympathy" would be clinically advantageous in situations that demanded rapid recovery of

anesthesia consisted of giving repeat surgery. The nurse described sterns made that have been available. Referring also to Mrs. Markham's husband Lady Hamilton asked: "I could never look upon the quasi rule simply without the greatest contempt." Dr. Watson wrote of the great kindness of Mrs. Markham and how there are no many without the world. His is much bettered by all the ladies here who speak of her with great affection and respect."

The Rev. Markham's married his wife a most shadow and suffering from a low fever and the shock which her arrival had occasioned must return early to England. His only previous admission to Thorpe Hospital had been on 28th July 1855 for three days for diarrhoea. The Markhams left on the 5th November 1855 after the fall of Annapolis on September and the virtual end of hostilities. They were accompanied by a party of several poor relatives, who could never speak of their amazing goodness without tears. Fear in leaving the man presented with an angina, whom we see and was treated. "Presented to Mrs. Markham by the Officers, Surgeons and Members of the Royal Navy employed on the Black Sea during the War with Russia, in token of their Gratitude for her unswerving services in their sick, and wounded soldiers at Thorpe 1855." His most previous possession was a letter from the Admiralty thanking her for all she had done and informing her that day to the officers of her work for them. These Ladyships had decided to keep a regular weapons survey, even in which would be taken for some part of the Royal Navy.

During part of her time spent at Thorpe the Rev. Markham replaced the official chaplain to the hospital who was ill. He was appointed an honorary member of the Officers' Mess, and served as camp and hard working in his wife Lady he was rewarded for his services as a Protestant services in the form of the Church of England and leaving out the words "may and certain before hope of the resurrection in eternal life. The excellent Institute known as the Peabody Company named after the chaplain at Annapolis who had introduced the Rev. Markham's services and made

the official protest. Admiral Grey strongly defended Rev. Markham and pointed out that he was serving as chaplain in his capacity and that the Rev. Peabody had no right to be at a naval service.<sup>10,11</sup> Naval chaplains also complained about the interest of the Rev. Markham. The chaplain to the Royal Bangle, who served at Thorpe Hospital told the Rev. Markham's presence was the result of a conspiracy hatched by the Assistant Chaplain at the Hospital.<sup>12</sup>

It is unlikely to complete the achievements of Mrs. Markham with those of Florence Nightingale. Within a month of her arrival Mrs. Markham visited the commercialised military camp hospital in Scutari in Asia. Mrs. Nightingale in fact from November, and Mr. Brocklehurst her personal friend and confidant, governed. They have quarters of where they cannot open for both of them. She described the hospital as a "highly place in camp, and it would need the Order of St. Stephen to cope." In contrast Mrs. Markham saw Thorpe Hospital as a masterpiece, and the only hospital with any degree of comfort.<sup>13</sup>

One can only wonder what would have resulted if the plan was Mrs. Markham and the authorisation Mrs. Nightingale had been reached. Could Mrs. Markham have possibly achieved her objectives without the obstacle that characterised the management of Scutari Hospital? Mrs. Markham herself did not think so. Mrs. Markham became the first female to be an honorary member of a Naval Officers' Mess. In most military circumstances would Mrs. Nightingale who was physically inactive, elegant rather than homely, highly intelligent, but being partly gypsy and a middle class<sup>14</sup> have been afforded a similar honour by the army? Sadly we will never know.

Much of the present highly romanticised versions of Florence Nightingale's role in the Crimean War assumes that her reputation should be judged on her failure to open her work under to that of the Military Commissioners, even when neither the medical nor nursing staff had any influence. It was rather ironic that combined together to build her lasting reputation. As with Queen Victoria the Queen's Government of the



Figure 2. Rev. Mrs. P. W. A.

Second World War she was president of Elizabeth Blackwell and Florence Nightingale and their names in the battle soon showed the influence of those cited enough to share the risks and discomforts. What about would have replaced with women in the uniform and apparently the British public as the war the war was going badly and it is the context that the Government would have welcomed a female dominatrix similar to that used by John Churchill in the First World War. They would not have been welcomed as protecting the image of the dominatrix Florence Nightingale. Most importantly the care in Florence Nightingale the transformation of nursing into a profession acceptable to "young ladies" rather than a job for domestic servants. As early as 1862 the Rev. Thomas who was active in hospital and nursing reform in Liverpool recorded the consequences of this change in the *States of Ireland*: "There was a year when it was not English for a well born lady to nurse, a respected British mother too we believe now it will never occur to be English." "Fifty years after the Crimean War the middle of a popular magazine for girls, *The Girl's Friend*, noted in *Women* was the most popular feature of modern history. Florence nurses were valued and of the 500,000 votes cast 120,776 were for Florence Nightingale." Eventually she had become an icon.

Returning to Scotland on estimated wages, Mrs. Macdonald could not nurse further campaigning took no further part in nursing reform and died in Edinburgh on 18 September 1952.<sup>14</sup>

### The Angels of the Crosses

There was appeal to her a desire which was suggested by the National Health Service union Unions to re-evaluate the role of Florence Nightingale the Angel of the Crosses especially in comparison with Mrs. Mary Macdonald. This campaign received widespread publicity in the national press between the 21st April and the 1st May 1966.<sup>15</sup>

Mrs. Senoide a Croix of Commendation desired who was born in Kingston Jamaica was formerly a health-care expert. Because of her practical knowledge of many aspects

desires including shields, that she had helped in her friends in the Caribbean and Central America, she earned a reputation variously described as brilliant doctor's nurse, physician and even manager. She never accepted without her medicine chest and would substitute for the doctor in any community that lacked that service.

When Mrs. Senoide arrived in London Florence Nightingale and her group of nurses had already left for the Crimea. Despite the fact that Mrs. Senoide's experience would have been invaluable when she applied to join a later party of nurses she was rejected by Mrs. Macdonald and others responsible for recruitment. Describing herself as "a little better" a few degrees cooler than the nurses whom you all select so much, she explains her rejection to at least in part her colour.<sup>16</sup> However, she must remember that a large number of applicants including Mrs. Macdonald were not accepted.

At the beginning of February 1855 Mary Senoide arrived at Constantinople. By then most of the major battles including the famous charge of the Light Brigade had taken place and the siege of Sevastopol was underway. Mrs. Senoide was Florentine, Nightingale in Boston who asked in her extremely practical and business-like way:

"What do you think Mrs. Senoide - anything we can do for you? If we have no power I shall be very happy." She was given accommodation in Boston with a number of women describing the time that elapsed but that night, as the only substantial experience in all Turkey.<sup>17</sup> It appears that Mrs. Senoide by this time did not work on

appearances to a hospital nurse as she was already committed to groups of British nurses published her ideas. Setting up alongside the railway she kept opened in the winter side. The British fleet which was essentially a restaurant for serving officers.

Lady Alice Macdonald described the first and never-varying good nature she exhibited to all her subordinates. Her dress proved to be a perfect Claspnet Skirt which was partly discoloured, a new dress was transferred that she had during the time of battle and on the issue of hospital duties personally spent no time, and the nurses in turn



Alice A. P. Macdonald  
of her life

the field of view and consider with her own hands what things as could comfort or alleviate the sufferings of those around her. Being young, so much as could not pay, and so many whose eyes were closing or dimly from whose persons could never be expected.<sup>14</sup> Although she was never officially a nurse, when opportunity presented and did so in the dockyard at Haslemere, she would dress the wounds of the battle casualties and administer medicine to the sick.

During Mrs. Bennett's time in the Crimea, she met and described<sup>15</sup> in a literary style someone of Elizabeth Dumas' name, one of the persons, who appear in this article. Admiral Boscawen's first illness had rendered her utterly helpless. Often at night by dawn when he was a wounded man being nursed patiently, she would move beside him at a couch with an ead that was strongly like a power and body the same, her hands, when taken away from him, were frozen the cold declined a cooking challenge by Mrs. Bennett, declaring that Madame proposed a dinner which victory would not give him his reputation for gallantry and be more disastrous than defeat.<sup>16</sup> She had many others, quite well of Lord Raglan, who was commonly in the saddle looking after his suffering men and selecting plans for their rescue.<sup>17</sup> W. H. Russell the prominent thought highly of her development only as a nurse but also as a physician.<sup>18</sup> With the addition and of her letters and the withdrawal of the French, Mrs. Bennett was caught in all her stock and financial bankruptcy. She was clearly both an angel and a devoted but it would be hard to judge a woman who advanced the standard of professional nursing.

There were many "angels" known and unknown in the Crimean War and it is impossible to attempt to rank them. Included would be distant ladies, mothers, wives, sisters, charitable houses and many others on both sides who like Mrs. Bennett visited their loved ones. Many not only loved but would themselves but also carry out their duties, sometimes conspicuous before and others all others. Of others, which could fall as a few being, as you read "if there be a recovery, we are 1 to 100" in one week, six British doctors, including the deputy surgeon of hospitals were among the hundreds who died of this disease.

#### "Lady" Nurses

Because of the poor reputation of nurses at that time of war, full necessary that ladies should

supersede them. For example, nurses who soldiers promoted to ward a war the line being extended from a higher social class I would therefore be expected that Mrs. Mackenzie would include lady nurses as well as paid nurses in her party. The nurses duties reported of the lady nurses were as it must, approximately. Even at Thorpe Hospital, it is reported that one lady was always in attendance to prevent anything that might be perceived.<sup>19</sup>

The practical work expected from a lady nurse might be rather easily understood by its mention in letters at the time. South Africa was when a sick soldier was approached by a "lady nurse" he replied, Please Miss I have already recovered (14 letters in they shall reach my flag) by the first World War the day was made the first. Vera Barstow, a young volunteer nurse (Nurses Aid Society (NAS)) wrote from United University, was sent in the 1914-15 war by her nurse a professional nurse as a maid of all work, and was constantly praised for their moral nursing work.<sup>20</sup> Another VolD noted was the mother of one of the soldiers (RQD) was ordered to clean the washing facilities. Fifty years later the red cross maintained the same system the original where she had to ask the order how you cleaned a bath – a task she has never previously undertaken.

Major problems arose in the early days of the war despite Sidney Herbert's statement that they were in equal, the "lady" nurses refused to wear the uniforms, which they saw as a mark of domestic service. They also expected the paid nurses to wait upon them.<sup>21</sup>

The moral management was not immune from such problems. Mrs. Mackenzie commented that ladies in her party wished to make Middles and Bantons of the nurses, which they are not to become.<sup>22</sup> She was almost as that a woman undertaking private nursing at that time would have expected the nurse to wait and to wait upon her just as the hospital Cooks Camp was visited only by the maid in the house where she was nursing.

Dr. Wilson gives a short description of the first lady nurses at Thorpe Hospital.<sup>23</sup> He described Miss Lytton as "well educated in a dignified manner by paid maids. She is a delicate lady, or perhaps, merely 'lad-like'" but a devoted creature." The most serious illness among the lady nurses occurred at February 1855 shortly after she had arrived.<sup>24</sup> A case had been sent to Thorpe on the 7th December only a few

does before the nurses arrived.' The Rev. Elizabeth de Larnier joined Mrs. Hamberton without ceremony thanking her 'in the parlours of both hotel and house for the courtesy of her charming presence.'<sup>12</sup>

Mrs. Anne (Nurse) Macdonaldson Doreau, had a laughing smoking partner; there was 'light and merriment perpetually in return, nothing comes more easily to do her work however manual and arduous, with speed.'

He was clearly disappointed by Miss Emma Hambley, who was without a companion the sisters had 1 day set eyes on Emily and all 30 who spent her days when suffered on board the Quetta and her night in setting up in the wards. Talking in taking leave, called up her mind to do and you better somewhat related to her own experience.

One of the worst nursing problems had we, and hence the first book passage not again but was refused permission to enter the hospital for Dr. Davidson had been stopped home yet again by the Admiralty.<sup>13</sup> The officer would appear to be Miss Hambley who having been attended for fever on 11 February 1855 was discharged from the hospital in England on the 23 April 1855.

The official preliminary report on the medical services of the navy records the names of Miss Hambley and Miss Veyre but none the name of Miss Hambley. Miss Fendley and Miss Veyre stayed until the hospital after leaving 1775 patients stayed in 25th July 1854.<sup>14</sup>

#### Professional Nurses

Mrs. Macdonald stated that her girls would consist of six nurses, one of whom would be a lady of experience. She was aware of the likely problems of the appointed hospital nurses individually and she was also wary that many of the Protestant nurses from the Anglican Board of Missions might well view their family as inferior and do nothing else in the sight of wounds.<sup>15</sup> The army surgeon Dr. Watson did not share their views on the 14 Anglican nurses recruited by Florence Nightingale. Having looked at most of them who nursed in the Crimea War – an extremely early undertaking. These Anglican nurses had had previous experience nursing children in formal institutions in the sphere of Physicians.

Like Florence Nightingale Mrs. Macdonald hoped that the Institution of Nursing Sisters would supply her need for experienced Protestant Nurses. Mrs. Macdonald's letter Dr. Chalmers was a friend of the wealthy Tenny family of Norwich and which Elizabeth Fry had

been loaned Aldington by Mrs. Mrs. Fry intended, the connection reversed Mrs. Macdonald would have been well served when she approached the Institution.

A perusal of the names of naval patients in Thorpe's Hospital<sup>16</sup> shows that Irish and probably Catholic nurses are uncommon and therefore unlike Florence Nightingale Mrs. Macdonald may have felt an appeal for a 'balanced' group which included Catholics as well as Protestant nurses.

The background of the two professional nurses not recruited from the Institution is unknown and they may possibly have been Catholics. However if some Irish or Catholic or even Anglican Protestant were in the group, their status as the Thorpe's Hospital nurses took respect of patients would probably have been accepted as 'neutral' rather than none.

The Thorpe's Hospital nurse book, which lists the patients who were attended for treatment, proved a valuable source of information. Comparison of the names of the Ladies Commission that ran the Institution of Nursing Sisters, and the nurse book for Thorpe's Hospital has identified three professional nurses who accompanied Mrs. Macdonald from the Institution, although she states she only recruited two.<sup>17</sup>

Unlike Elizabeth Doreau the *Reluctant Nurse*, 'as professional nurses were about the Crimea War. Because of the social pull between the many mothers who did some of their experience and the "paid" nurse nothing about three professional nurses has been recorded by name in Thorpe's Hospital. From the official Dr. Watson Mrs. Macdonald's friend was assured when he was requested to consider with a response to a doctor party.<sup>18</sup>

#### Against Velle

She worked on the Institution of Nursing Sisters from the 15th February 1854 to the 17th December 1854 Anne Wells was the only one of the original six who having volunteered to accompany Florence Nightingale left for the war. She had previously served various institutions including mental asylums, parishes, convalescents, and 1800-1810. Over time taking children in childbirth. Her references from each one were unexceptionable being consistently described as highly satisfactory – 'her services have been procured and the attending' the patients at Thorpe's Hospital was attended from the Thorpe's Hospital nurse book.<sup>19</sup> A book recorded





night the whole made most dismal by the light of candles and lanterns."<sup>10</sup> The day after Sevastopol fell (after Edward Craig's arrival) surgeons visited the Russian hospital patients, although almost if not all the living exhibited signs of what it had been and would be, even if cured!<sup>11</sup>

**Other Naval Hospitals Active in the Balkans**  
The records also then indicated by the Naval Brigade when fighting along the army during the siege of Sevastopol (October 1854–September 1855): "a small hospital hospital Komaruk Bay Hospital capable of holding 12 patients was opened on the 15th May 1855. It was used 140 feet above the sea on the heights (above Balaklava Harbour) exposed to the full onslaught of the sea" and "designed to be beyond the influence of enemies." The hospital was situated amongst the rocky hospital the Sevastopol Army known as the Castle Hospital had been constructed by a garden of wild flowers, trees and ornamental plants. The surgery of the war would have contributed to the construction of the Secretary Commission that the Castle Hospital was one of the most healthy of which we have records."<sup>12</sup>

Overseas previously being treated in the hospital and visiting ship HMS Diamond capable of holding 24 patients and other surgical staff were sent transferred to the land hospital as the change of medical culture occurred from the ships Surgeon Smith and Assistant Surgeon Fowler of the Diamond. The primary reason the Secretary Commission recommended a move to a shore hospital was the ill-effects of the harbour, which was filled with the carcasses of decomposing animals and sewage from the anchored ships. The Diamond's captain Captain Hamilton, although his signature on the arrival of the patients continued to put daily visits to the hospital.<sup>13</sup> The hospital was closed on 28th September 1855 when the Captain of Sevastopol arrived there and being taken rapidly to the hospital by ambulance.<sup>14</sup> During the period of its operation, 117 cases were treated 88 of which were wounds in surgery, 18 proving fatal. No medical cases appear to have been fatal.

The condition of the 1858 officers and men of the Naval Brigade who were killed at Balaklava in October 1854<sup>15</sup> were successfully recovered, because the sailors considered it unlikely when at night of the centre in dock behind the parapets. "Within a short time they had adopted the discipline that necessary prevention of what is vulgarly called 'slopding'." In

contrast, their health was superior to that of both the army and sailors.

The reasons for the comparatively good health of the Naval Brigade are complex and are considered as stated by the surgeon of the Russian hospital, William Smith.<sup>16</sup> Having to deal their usual guns first priority was position and then having to live in trenches caused conditions for them were as hard as for other troops involved in the Sevastopol siege. Nevertheless once they were established, their accommodations and working arrangements were superior and the food and drinking was, by comparison with the army and Marines, unusually satisfactory. From the very small permanent supply of frozen game was added to them. Later in the spring of 1855 a plentiful supply of oranges and lemons became available which, at the suggestion of the Doctor General had been collected up from the Mediterranean in large quantities in anticipation of the approach of winter, although the men employed in the fleet and trenches. Compared with the rags of the soldiers, the sailors were so well supplied with clothes they were able to sell their spare pilot coats to the army officers! The difference in health between the sailors and soldiers was also related to their gross fare. Alexander Layton, appointed Director General of the naval medical services in 1864 had no sailor service in the Crimean War, but provided an explanation then. The sailor is a better cook, a better toilet and even a better cleaner than the soldier and by an means something so appropriate to the tastes of his associates, whereas military doctors find horses they throw in his way.<sup>17</sup>

After the war Dr Davidson and Dr Barry both completed the the positions of Deputy Inspector at the Naval Hospital in Malta. Davidson was decorated by the Admiralty command in a good surgeon and conducted the duties of Thomas hospital with great ability and skill. Barry who was given the position was one of the most able and accomplished surgeons in the Royal Navy. He had served in the Crimean War (both land and Diamond Hospital Ships) where the sick and wounded of the British and Royal Marine Brigades were recovered.<sup>18</sup> One cannot but wonder if Dr Davidson's earlier leave in the Admiralty department to demand a home posting had played a part in the selection.

There is general agreement that the success of senior officers such as Captain Koppel in the



developed.<sup>12</sup> As that area was an anchorage for the fleet, it would have been well used to support smaller camps as they occurred on different naval visits as well as at intervals. Certainly a contemporary chart published 1815 (in 1850) shows an apparently well established Naval Hospital with six buildings and surrounding walls on the west point of Koonah Bay.<sup>13</sup> There appear to be no allusions to the first hospital mission states that the hospital was situated "near the light-house"<sup>14</sup> - in the very top of the headland, and everywhere in the hospital there is a "small circle on the chart suggesting the presence of a light in view of an allusion and it appears more probable that the light-house referred to was a tall white light-house<sup>15</sup> slightly less than a mile away from the hospital in the west. This important light (14 ft) with surrounding buildings was at Cape Koonah.<sup>16</sup>

It and where the medical mission established the hospital would have proved a useful stopping point for passengers seeking provisions from the headland in many days weathered on the way. To appreciate the busy of Lord Blyden,<sup>17</sup> departed from when died from exhaustion after diarrhoea ("chills") a few days.<sup>18</sup> RMS Courier, an east public postman from Koonah Bay rather than the harbour at Koonah.

Captain Kappel thought it advisable to have such and passengers restricted having the necessary camp material they were ordered to stay calm home using the doors; passengers either located on which it required the support to perform on not first when all were on board. Later he limited a tent to about the primary suffering from the highly infectious disease. He gave a brief description of the hospital tent. Having obtained the names I endeavored to say something concerning to each. These tents were erected into the shape and appearance of large plain buildings with doors, their own motion could not have movement from. Framed by the doors it was able to say something about its right and could say by a single name of door heads that it gave pleasure. Building built, making walls and words about a hospital, an arrangement.<sup>19</sup> Throughout the campaign it was noted that persons vaccination recognized by the rule with this total exception had an effective role in understanding the disease and limiting its spread.<sup>20</sup>

Marines were based at Espoussin (Thryphosus) all males with word of Koonah when the army avoided the Contact in September

1854. A garrison including 400 of the marines was ordered there to defend the town. Because a war, packed on a number of occasions, the number was increased in the end of that month. After being replaced by 100 marines, most of the marines had been withdrawn from Espoussin by December.<sup>21</sup> They would probably have had a tented or perhaps even a tented hospital during this period. Moore is made by Dr. Theo. Chandler (184) of Captain Kelly received from Dr. Davidson, who has performed wonders in meeting our needs. The Koonah and Espoussin, suggesting some surgery at a hospital at the time war is that time.

Although two covered<sup>22</sup> mention a large naval hospital<sup>23</sup> located on the Cronian Peninsula at Espoussin, it is doubtful if a hospital of any significance existed there. Some confusion may have arisen from Captain Kappel's ambiguous description of the use of the small hospital tent established.<sup>24</sup> The tented and such were provided from the ships of Koonah were immediately evacuated to Thryphos, a much larger journey than to Espoussin, which would have been the destination of almost all officers general hospital had enough on the last war.

The Mission actively participated in the establishment of Koonah which named in October 1854. During the time when this a thousand marines were at Koonah, the Agreement was made suitable to make them residents.<sup>25</sup> In addition a post camp was then established hospital was constructed on a camp ground on the slopes of a cliff.<sup>26</sup> Throughout the campaign the Mission appears that the army hospital built in the Golden Horn to have fallen between our hands with neither the army nor navy really responsible for their welfare.

Being more looked upon as part and parcel of the army and consequently received when not into the military hospital.<sup>27</sup> Dr. Theo also complained that he had received no information of the Espoussin Battalion.<sup>28</sup> Although primarily being naval medical officers responsible for them, the Mission did not appear to have secured the medical attention given to the Naval Brigade, which was commanded by the efficient Capt. Kappel. The high death rate of the Mission was subsequently attributed as being in part, in neglect by the naval support at change. James Wilson (Espoussin) appears to have been somewhat disturbed the service and remained some years in prison where he died. He appears to be another victim of the Mission failure that prevailed after the war.

Florence Nightingale's continued wisdom however well intended she may have felt it is to be as open for John Hall, the senior army medical officer on the Crimea, did nothing to quash these hopes. If there was truth in this relationship it lay on both sides. Mrs. Davis the "Balaclava Nurse" states that in order to introduce a new system of management in the Crimean hospitals, Miss Nightingale called together a board of medical officers in the Castle Hospital and herself took the chair when they assembled although Dr Hall was there. No dissenters surprisingly after what in that time would have been perceived as a studied snub took Dr Hall and Dr Anderson Principal Medical Officer at Balaclava refused to attend the site. "The subsequent funeral of the RCB (Royal Commander of the Castle) Dr Hall was ordered to be her son, Knight of the Crimean Burying Ground".<sup>14</sup> The unknown "mother" was, in one way, the John Hall called Florence Nightingale a friend and companion in Crimea. Mr. Brockbridge "The Honorable Brockbridge" and army medical officers often unwilling to cooperate, would ask when the flag was flying about today. "When a little help might have saved the burden. It is the King's duty they would say".

From the war it was necessary for convalescence in Turkey to have a small hospital in some desert area nearby. As the majority of the patients in the hospital run by the British Embassy were women it was commonly referred to as "The Woman's Hospital". It was also sometimes called the "The Maid of Hospital" although a hint no direct link, into the Admiralty. Originally behind the entrance the old hospital was rebuilt during the war at First class in Constantinople and became "one of the best establishments in the East".

Since Emily Carr had been sent by the Institution of Nursing Sisters in 1846 to study midwifery, nursing in Constantinople. She returned the Ladies Committee in April 1848 that she had been appointed superintendent of the Russian's Hospital, which was described as three hundred in size facilities. As treated women were not allowed to move for the Institution, she was discharged in July 1857, when news of her marriage reached the Ladies Committee.<sup>15</sup>

The First class hospital, known by name from Constantinople, was the only military hospital in Turkey to admit foreign females and it is well as the French hospital received practical support from Miss Nightingale.<sup>16</sup>

Although female nurses including Elizabeth Davis the "Balaclava nurse" were provided for the army hospitals in the Crimea, there is no evidence that female nurses were stationed at any naval hospital other than Thorpe.

#### The Navy's Most Famous Patient

During May 1855 Florence Nightingale was severely stricken with fever, the diagnosis of which remains uncertain. Among it as a plot by the medical staff to not dissatisfied of a treatment she declared there suggestions that she should be evacuated from the war zone. Dr. Nathaniel the senior surgeon of the upper of the Sanitary Commission who acted as her physician advised her in July that the journey to England would be too great a strain. She should either go to Switzerland or leaving that the naval hospital at Thorpe, where a room could be reserved for her. On 25th June she entered Thorpe Hospital as a patient. She was too weak to find herself or speak about a witness.<sup>17</sup>

Her arrival at the hospital was supervised Florence Nightingale was found in a letter "by the soldiers, who made replies without number under strict direction, in that the greatest possible number might have the pleasure of helping her and her hospital was divided among 17 patients though two could have easily carried the whole".<sup>18</sup>

With a diagnosis of "Convalescence from Fever" she was treated with the Thorpe Hospital nurses took with the title of "Maid nurse" whereas Mrs. Mackintosh was called an "nurse" and the three "Maid" nurses and the three professional nurses in Mrs. Mackintosh's party were referred to simply as "nurses".

The records by the nursing staff of this by now famous lady must have been somewhat uncertain! She had advised Mrs. Mackintosh's sister in 1844 to assist the army on the grounds that there was no room for her. She had also expressed loss of the nurses from the Institution of Nursing Sisters, who had volunteered their services on the grounds that they did not understand electricity.<sup>19</sup> (This explains why Anne Wells who was one of the ten original volunteers ended by serving in the navy rather than the army). The rejected nurses, who were subsequently accepted for the naval party, were described as much overworked Mrs. Mackintosh maintained that they were anxious to prove their fitness and she would do up the sails, and what better chance were by taking them.<sup>20</sup> Florence Nightingale was discharged from Thorpe Hospital after what must have been an

increasing time days? The British Ambassador showed her the French Prayer in Fries for her grandmother but she preferred to return to Susan's tale from that I think also she had left for the Crimea where she had become ill."

From the letter she subsequently wrote to Mrs. Mrs. Louise Pittman Pylingdale appears despite any personal problems or loss, thoroughly enjoyed her stay as a guest of the navy.

Boston July 1873

My dear Mrs. Mrs. Louise

I have not the things Mrs. Andrew asked for I found Mrs. Pylingdale things suffering from over dress quite without proof that we have had some children in the hospital it is so well that I should be at home

It is very much better here than in America that I believe as much I have rather under your kind care and as your hospital are that I hope I shall be contented with the facility of your way and you are much I thought about for all your business

With my best love and thanks to all you and yours and hoping you are better than when I left you

Believe me ever yours

Flourney Pylingdale

I hope your patients are not overworked, we received 500 each last week from the Crimea but the children more so as the demand"

## Conclusion

It is fairly enough comparing the moral hospital with the very highest of health's was coming by a discussion of Mrs. Macdonald's words "the comparative efficiency that the women bring about?"

Although having it was until 1st April 1873 we IT trained nurses to enter the moral nursing service formerly the nurses at Thomas Hospital were the ladies who produced the present highly professional moral nurse. It is especially wrong that these early nurses should be recognized as the ordinary year of the Queen's Nurse - Royal Naval Nursing Service

## Acknowledgements

The authors are indebted to numerous individuals, referees and libraries. They especially thank the following who have assisted in the numerous occasions Captain John Henry RBC, Queen Alexandra's Naval Naval

Nursing Service Archives, Institute of Naval Medicine, Queen's House, Mrs. Andrew's Director General, Hospital Photographs Museum, St Thomas's Hospital, London, Mrs. Macdonald, Captain Andrew's Library, Great Scotland Yard, London, Miss Colin Baker, Editor of "The Correspondent" Journal of the London War Research Society, the Staff of Hammersmith Public Library, Northall, who over the years, ably assisted numerous old, national banks. We are also grateful for assistance and advice in research work to Thomas Beachell, Tony Gower and Elaine Huxtable and Nancy Thomson.

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## History

### The Establishment Of Queen Alexandra's Royal Naval Nursing Service

The following text, as held in the DAWN5 archive in the Institute of Naval Medicine (the author is unknown).

On October 16th 1902 Queen Alexandra, wife of King Edward VII wrote from Sandringham a long signed writing paper on the Queen was still at Sandringham for the death of Queen Victoria within that year, to Lord Selkirk, First Lord of the Admiralty. The letter reads:

Dear Lord Selkirk:

I am well & believe I have heard about your Army Nursing Scheme of which I am proud to be President and that it should bear my name. May I tell you the great work of my heart has always been to see a the Army Nursing Department also under my special charge and that a way should be found to unite and be amalgamated with the Army if possible.

Please let me know, my name is now one of you are able to carry out this great work of mine and I am sure you know the intense interest I have always taken in our Navy.

Believe me yours

Very sincerely

Elizabeth Alexandra

Lord Selkirk's reply:

Lord Selkirk's reply is complete that it will give the nearest satisfaction and pleasure to His Majesty's Navy that Her Majesty should become personally associated in it as its Honorary President of the Navy Nursing Society and that the whole medical department of the Navy, and especially the Army will feel greatly honoured by the expression of Her Majesty's wish.

Lord Selkirk's reply will have no more to do with the steps which might be taken in 1902, and Her Majesty's wish (October 16th 1902).

His enthusiasm was unquestionably shared by several members. Lord Walter Rieu-Laporte, in turn the Navy Nursing Department under her (the Queen's) special charge and that it may have her name will be very much appreciated by the service and the effect cannot fail to be beneficial. There was a precedent for royal interest in nursing matters in ten years earlier Princess Christian, Queen Victoria's daughter had accepted the Presidency of the newly formed British Nurses Association.

After some time the income awarded the Naval Nursing Society, of having the Queen as their head, the interesting point is her suggestion that they should be amalgamated with the Army colleagues through by adding "if possible" the Queen shared her awareness of potential difficulties, since the two services were not joined in any other way. Lord Walter Rieu-Laporte stated that he felt it would be rather difficult due to these different considerations, and added that the First Lord's reply does not pledge an to great amalgamation. One of the obvious differences between the two was that the proposed Army Nursing Service was in control of a Minister in Chief, Principal Medical Officer, Surgeon and Navy, whereas the Navy had 3 Head Quarters and 10 Districts in 1901, although it was anticipated that the number would increase in war time.

In the same month as the Queen's letter was received, a detailed comparison was carried out of conditions in the two nursing services. This was necessary because whether amalgamation went through or not, the two services were sufficiently similar in their work for standards to be made as equal as possible. Age and qualifications on entry for applicants were identical. Pay was more complicated because of the different rank structures. Initially the Army Nurses earned more than their naval equivalents and the First Lord's in 1902 earned £100 per annum maximum compared to a Lady Superintendent £120 maximum. The Head Nurse at Chatham, presumably because it was a



casualty hospital, named only 158 men and women, for Nurses and Wounded men and women patients. Army doctors received fewer men, but were given a clothing allowance denied to the naval colleagues. There was a difference in the training age, which was 35 for naval fleet doctors, 30 for doctors, but 60 for surgeons of the Army Medical Service. Powers rights matched those set, as naval rules had been assimilated to the Army's by an Order in Council of February 1864, the only case being excluded long service in the service before that date who were permitted according to former rules.

One standing block on the way to uniformity was the orders, failure to serve abroad. As the Army Surgeons had more service abroad, their regulations were more explicit. In terms of the Nursing Service will be large in the future of the Queen's Commission, and as a general rule, those who have been for the longest period at home will be the first to pass the award. In 1864 the Navy had five doctors serving at the hospital in Malta. Of the remaining 23 doctors, 12 who had entered before 1860 were not liable for foreign service, leaving only 11 who were. The relevant regulations stated that the doctors of the Fleet Surgeons and Nursing Service will be located in the Hospitals to which they are attached, but they will be liable to be transferred to other Fleet Hospitals in home and abroad as well as in exceptional cases, the Hospital Ships. Thus it can be clearly seen that a naval Surgeon could not be called upon to serve at an Army hospital. As there was no provision for it in the regulations, incompatibility with Army orders was impossible. Hence, the regulations were changed, which would then not be the same conditions of service, something not to be undertaken lightly. It would appear that there was no wish to do this, as doubtless the naval authorities desired to retain their own nursing service.

The passage of Queen Alexandra created a change in the Surgeons' uniform badge. Formerly the Army had eagle powers had carried the Queen's badge, a red cross on a white background, carried in gold on the right sleeve above the elbow. To this was added above the cross the Majesty's Commission of two A's (armstrong) and not wearing a gold anchor and Latin cross. The white was substituted by the Imperial Crown. This simple but design was approved by King Edward on January 28th 1902 and promulgated by an Order in Council. It was introduced up with an understanding

and 1864 as the corner was reserved for the old style medical unit.

Later in the year some talking up measures were required to regulate the Army and Navy Nursing Services at the important issue of pay and leave. It was decided to pay the three Royal Naval Surgeons the same rate as the Fleet Surgeons, as it was, shortly to be made so the previous General arrangements and there seemed no need to produce the Fleet Surgeons. The same rate for doctors was fixed to £37 10s. In the year the Army nursing posts (Nurses) and working differences were also distinguished in Army lands by leave too, the naval allowance fell somewhat short of the Army's, though by only a few days. Annual leave was fixed at 42 days for Fleet Surgeons and 18 days for Nurses. In a Minute of September 1st the Director General was instructed that the above points, and retirement payments too, should be carefully compared to the two Services, should be "on the same parity".

The regulations published on November 1st 1902 have a new heading on them cover it read

*Queen Alexandra's Royal Naval Nursing Service*

*Provision*

*Her Majesty Queen Alexandra*

These regulations were an updated version of those of 1888, which in turn were based on those issued in 1867. They were attached mainly to 15 sections and 45 subsections. Many particularly those involving the duties of the Fleet Surgeons and Surgeons their supervision by the Medical Officers their movements of the Fleet, North Staff their pay, and disciplinary procedures dated back to the original regulations of 1864. One new clause however came up on the naval paragraph stated that All Nursing Service will be required to stand up 12 months, perhaps better, they are appointed in their appointments. Should they then be, appointed upon a 12 months term, for the King's Service they will receive an appointment signed by His Majesty Queen Alexandra and their names will stand their date of entry.

There were also new paragraphs, it was stated that candidates, must produce certificate, of standing in at least three years at a large civil hospital in the United Kingdom in which shall make patients are received the

Medical, and Surgical treatment" Applicants were to be of British birthplace. The education of the professional seafarers expected was possibly less than a third of the total towards certification going on to civilian training which would come under the Royal British Marine Association. had received a Royal Charter enabling us at the time to maintain "a list of persons who may have applied to have their names entered therein as nurses". The Association had waited for 40 years of Nurses but this was the response received. The days of the public interest, the lady nurse would work evening shifts, were far behind. All appointments, transfers and dismissals were to be dealt with in the Admiralty. They could state on patients after two years, patients if moderately well as in the age of 50-55 for First Section if they can have service through France was to be considered which on entry but eligible persons could be passed in any case of special devotion to duty. Transfers between hospitals on a new appointment was made either by the presence for the rest of First Class railway passes for all Nurses.

A short clause in Section 40 was added as attempt to keep the Nursing Staff more closely under the control of all the Medical Officers. It states "Letters from the Head Nurse or Nursing Sisters to friends of patients are not to carry any medical opinion whatsoever on the case unless by permission of the Medical Officer. Moreover the Nurses had taken orders from

Medical Officers only on matters concerning general nursing duties in the wards, common night duties and the time in the theatre. They were on duty. Increasingly also, the work done which concerned a Medical Officer, namely the examination of a Sister in the Post Room was incorporated in 1902. To allow this if necessary, in 1902 his report on to the Principal Medical Officer of the Hospital as a Nurse to the Director General. The discipline, right, a new one. It concerned the discipline "Nothing remained as the discipline, regulation is to be taken as following the Head Nurse and Nursing Sisters from her subject to the general control and supervision of the Principal Medical Officer of the Hospital to whom they are attached."

It could perhaps be said that the former Nursing Staff which through the Imperial Naval programme had grown in status by the time of 1902 had already drawn more than half the work of the Royal Navy which served. It was the beginning of a process which resulted in formal recognition 15 years later in 1917 when members of Queen Alexandra's Royal Naval Nursing Service became subject to the Naval Discipline Act 1902. However the staff was so increased and methods a review was made and was to remain for some time.

*Formerly Queen Alexandra's Royal Naval Nursing Service was incorporated into the Royal Navy on 1 April 2002.*

## Travel and Adventure Down Under On Exercise Longlook

Armando Boari

Exercise Longlook is an annual Tri-Services (sea, land and air) exercise operating for 4-5 months open to all participants. The aim of the exercise is for personnel to work in a different environment and for the host country to benefit from their participation in the workshop. It is conducted on a reciprocal basis with participants usually being employed within their usual specialty. I was appointed to Holsworthy Naval Hospital (RNH), Australia. RNH is situated within HMAS Program (in influence on Sydney Harbour HMAS Program is one of the National Fleet and approximately 12 vessels drawn from the crews of Sydney and the Western Fleet, such as: Manly, Carl Carl and Fife, Brindis and Roma and Away fleet) and 30 personnel from British Royal Navy were guest crew for the being 3 weeks bodyboarder.

HMAS Program also contains the RAN (Royal Australian Navy) School, RAN Staff College, RAN (Naval) School and Police Command School. RNH is a single facility within the Royal Australian Navy (RAN) health service at a 16 bedded hospital unit is the only Australian Defence Force (ADF) health facility fully accredited by the ACHS. The hospital only provides support services for RAN and other defence force personnel. It provides outpatient services for local defence force personnel and auxiliary services including audiology, medical pathology, physiotherapy, pharmacy and dentistry. Many of the services provided to the ship borne Frigate Command (Western Fleet) (FLC).

Exercise Australia is an island nation the RAN will always play a vital role in Australia's defence. For its security Australia relies upon:

- A national defence capacity to provide for the national defence of Australia and its interests against threats that could arise in the region.

- The provision of a global security, consistently in South East Asia and throughout the Asia Pacific region.
- The continuation of an alliance relationship with the United States.
- The maintenance of a high level of defence commitment to the UN and other multilateral organisations that contribute to a more secure global environment.

The main training establishment is HMAS Cleveley at Warrington in Victoria where sailors receive all their basic training and receive development. Officers are educated at the Australian Defence Force Academy and then receive their naval training at HMAS Cleveley on Jervis Bay south of Sydney.

I arrived in Sydney in April after an opportunity via Bangkok, Borneo and Vietnam courtesy of the RAN who had fortunately obtained a civilian passport. I was employed as the military main supervisor within the operating department as there is no military and facility within RNH this being my specialty. My usual working hours were Mon-Fri 0700-1700 hours. The highest surgeons were experienced at patients being through the operating department occurred during an time at RNH. There was only one operating theatre and the main types of surgery conducted were orthopaedic, dental, minor general surgery, ENT and maxillofacial. Most surgeons were civilian or from all the Australian, recruited as for no operations days at RNH. There was one RAN surgeon trained in orthopaedics. The operating department staff comprised of the Nursing Officer in Charge, two civilian agency nurses, two RAN nurses that had completed ORP training and their RAN AB orderlies in various stages of their training. The department had an own CBRD which was also responsible for the cleaning of ship support equipment.

The working environment was much quieter than what I had been used to within RCT and I

Armando Boari, RAN (RNH) is now serving in (RNH) (RNH).

had no direct personal responsibilities in a consequence of him the distressed systems operator within RNZN I conducted informal teaching sessions with the medical students in casualty covering survey techniques, sight symptoms and treatment of shock, pulse oximetry, haemodynamic monitoring, cardiac arrest procedures, resuscitation pathway of the heart, basic ECG interpretation and basic nursing care of the anaesthetised patient. The clinical exposure that the RAN medical staff have is very limited as the teaching that I did was mostly for their post-graduate with the forthcoming implementation of the PCRF. I also updated the casualty resuscitation pack and contributed to changing the protocol for two persons, spent an evening just up and the introduction of a pain protocol for analgesia and paracetamol.

Having worked within the RN medical branch for 12 years, during severe defence cuts, the closure of RNZN Plymouth, amalgamation within Dorset Hospital and the Service, RH Hilder I was able to compare the two services and what progress experienced by the RAN medical branch particularly regarding morale, retention and clinical exposure. The RAN has a severe shortage of Nursing Officers and there are no Registered Nurses within the RAN employed in

casualty. Nursing Officers must be qualified Registered Nurses with a minimum of 12 month experience, preferably two years. The submarine force offers training as a Qualified Officer Course at HMSA Gosport. I see where there is scope for the QARNNS to be both an officer and ratings, a nice structure and opportunities for post-graduate courses are clinical as opposed to being far greater within the QARNNS. Some of the young officers were on operational deployment in Bougainville, Papua New Guinea and this is an ongoing commitment to the RAN medical service. The Commander of the South West Pacific got very, very close cooperation for Australia. The Australian defence relationship with Papua New Guinea was at the time of the Longfellow 99 the most substantial in the South West Pacific. Australia's support, commitment to be covered here by a capable, well educated and educated Papua New Guinea, able to conduct hostile external groups and well equipped strength in numbers. With the RAN medical branch having operational commitment such as this it is important that they maintain this clinical skills.

All medical personnel were undertaking training for their operational role within the PCRF attending 'study sessions and Royal Naval



Fig. 1. Medical personnel attending to a patient on a stretcher.

Wien. Hospital (continued) to support clinical shifts on the evening watches. I was able to attend a one day training course at the center with the medical team, the operating department. The patient population L&M is a mix of the age, sex, race of a real patient who can talk (anesthetized) and can be used for a broad range of operations. I managed to view the PCRP (Painful) Machine at the end of my exchange it was still in the process of being completed and is much smaller than RFA Aggs.

L&M's Machine and Kumbia previously served with the USN, the two Newport Class Landing Ship Tanks (LST) were acquired by the RAN in 1984 and are among the end of their class within-dollar construction and conversion to Landing Platform Amphibious (LPA) which completed they will provide the RAN with the specialized amphibious shipping required to deploy a light infantry group via vehicles and equipment. The LST has been here have been modified the bow door, reduced size and the forward deck, fitted to provide a light deck. The addition of a 15mm gun at the bow of the ship will allow the ship to also be used in many low army LCMs landing craft. The added capability the forward light deck can be used after the LCMs have been launched. The ship's structure has been changed with a large hangar at the bow Blackhawk or other rotary helo ops.

A medical facility has been installed on both ships to provide initial medical support and allow medical support to personnel ashore. The facility contains two full operating beds, two operating tables, two full operating recovery beds, and six high dependency beds. These meeting combined three more beds have also been installed to provide a 12 bed low dependency medical ward. Medical equipment such as X-ray machines and surgical systems will be permanently fixed however the personnel to operate the facility will only conduct when required. The main of the modification will be two ships that are each designed to conduct 150 troops, vehicles and equipment to conduct amphibious operations, plus a combination of reduced helo ops, medical support and. The task deck, accessed through the main door forward ramp or at least provides 500 square meters of storage space for vehicles and equipment. The work on Mawata is virtually completed and the ship is approximately an month behind the task ship then it is to undergo extensive testing and trials programs.

On April 25th shortly after one o'clock in the morning I was fortunate to be present during ANZAC Day. On April 25th 1915 members of the Australian and New Zealand Army Corps (ANZAC) landed at Gallipoli Turkey as part of the Dardanelles campaign. In the process thousands of men started the cliff descended by Turkish machine gun batteries and over 2000 ANZACs were killed on the first day alone. The fighting dragged on for eight months until December 20th 1915 when 90,000 men were evacuated and Gallipoli was abandoned. Approximately 2000 Australian soldiers died over the course of the campaign and 19,000 were wounded. ANZAC Day is an Australian national holiday observed every April 25th to remember the heroism of these troops. ANZAC day commences with a moving dawn service held in Sydney. I attended the ANZAC parade, the atmosphere is very different to our Remembrance Day. There being more a celebration of remembrance. Service personnel were then honored during the day and it is the only day during the year when they may play two up (a gambling game using snooker). The celebration continues throughout the day and night, a 24 hour war. It is a day well remembered.



Alan Mawata.



jump. The actual jump itself was 44m out to 50m, plummeted down and rebounded back, the landing was usually similar to landing, but didn't last long enough.

I went to Darwin, Northern Territory predominantly to visit Kakadu and Litchfield national parks. I spent three days sleeping at Kakadu which is a day boat ferry route of Darwin. The park is about the size of Wales and is owned by the aboriginal people. The Northern Territory is a vast flat and hot part of Australia with minimal habitation. Kakadu is very respected by conservationists I went into to see Uluru which has the world's oldest cave, paintings being aboriginal rock art. I watched the sun rise over Fogg Bay where I saw millions of beautiful birds on lakes, many species. I travelled by boat up the Mary River basin to plenty of culture and 'bushies' is considered and then stopped out in the bush. The most amazing system at Kakadu was, in how low and Tiers Three Falls. There are getting thousands in the wet season and only visible from the air. I was there in dry season (winter) and it is to roll up to 10 degrees during the day. Tiers Three Falls is reached by swimming. I 'swam' the river which would mean swimming due to the risk of crocodiles. Litchfield is a national park close to Darwin and doesn't remain open. There are

plenty of beautiful swimming areas and waterfalls and some impressive remote islands. Darwin itself is home to all three services, although the camp are beside the sea in Litchfield and the Mary are inland. Darwin has several beaches which are supposedly very low and Mabel Beach is famous for its apple market which runs plus, with Thursday Carabidgubers on the beach is much more. The market is one of the most beautiful selling very cheap and delicious food to eat all these.

I am wholeheartedly convinced Darwin Litchfield to anyone considering applying is provided me with the opportunity to work in a different environment, exchange ideas, build working links with the RAN medical branch and RANVAP personnel, appreciate the RAN Medical Service and of course to live and work in Australia, explore its amazing scenery and meet some great Australian people. This summer is an ideal way in which to promote Defence Diplomacy, as the spectrum of personnel and the members of the general public that are reached is fairly broad. To me Australia really is a country that has it all, beautiful scenery, environment of so many places in the world, great climate, friendly people and some great opportunities.



At school the danger of a deer deer kill

## Book Review

**Nursing on the Trenches Jordan 1901-1901**  
**Foreword: Histories of Queen Alexandra's**  
**Royal Naval Nursing Service Editor C M**  
**Layton Q&A&NS Association 2002 ISBN 0-**  
**9514588-9 £10.00 84 pp**

In the centenary year of Royal Passage of the Queen Alexandra's Royal Naval Nursing Service a former Master-in-Chief, Clive Layton, has written another a concise account of the history of the Q&A&NS interspersed with personal reminiscences of early years in the last hundred years.

What shines through this book is the remarkable spirit adaptability and sense of humour needed to cope in the Q&A&NS in it as a hospital ship off Gallipoli in World War 1 or as the right hand of a naval hospital.

Episodes of World War 2 include a moving

account of a private of war of the Egyptian Mau Gipsy Platoon led the sparsely armed and ill-equipped, under-estimated work as naval hospital and back Quarters and RNLI Home in Australia that lost Royal Canadian soldiers in the Royal Naval Medical Aid Association Unit and as Q&A&NS nursing officers come to life.

Post World War 2 conflicts, e.g. Korea, Falkland Isles, and the Gulf War are recounted as are the more humble sea personnel.

I would recommend buying a copy of this book for two main reasons. Firstly it is a fascinating account of naval nursing and Royal Naval Medical Service history for nursing and medical historians and researchers. Secondly the Q&A&NS 100th Q&A&NS 2002 Post North Q&A&NS Memorial Chapel in Portsmouth Colliery.

NEL



## Obituary

**Surgeon, Lieutenant Commander Julian Seymour John Hall Cottibury BSc, PhD, FRCS, FRACMS, FRC 1950-2001**

Julian Cottibury who died as the result of a tragic accident at Hong Kong on 11th July 2001 always manifested a great affection for the Royal Naval Reserve. Despite the fact that he lived in Hong Kong he remained committed to the Reserve. On one occasion when he difficulty in attending drill nights was noticed Julian stated what he would have to do as someone in the Royal Naval Reserve: he intended to attend a drill night and go on a training weekend (over the same month during a flying visit to the U.S. From this time on he was a very regular member whenever he was in Britain. In the summer of 2000 Julian was appointed as an RNR Medical Specialist in Toxicology and M&CC to the Royal Navy.

Julian studied at medicine at Edinburgh University where he also completed a PhD. From 1979-1988 he was a lecturer in the first year Department of Clinical Pharmacology at the Royal Infirmary of Edinburgh. He also had to compose publications on subjects including Pharmacokinetics and clinical pharmacokinetic methodology. In 1988 he took up the post of Chairman and Head of Clinical

Pharmacology in the Chinese University at Hong Kong. He contributed to well over 100 publications in peer review journals. He served on numerous University Committees and Panels, Authority committees and was a key person in supervising pharmacy courses within Hong Kong. Internationally he was the associate editor and editor of several leading medical and clinical pharmacology journals. In recent years he became increasingly aware of the growing epidemic of diabetes and the danger of hypertriglyceridaemia and obesity in Hong Kong. He played a key role in the establishment of the Hong Kong Foundation for research and development into diabetes. He established important working links with many overseas institutions including those in Medical China where he was Honorary Professor of Clinical Pharmacology at the Chinese People's Liberation Army General Hospital (PLA Hospital).

I first spoke to Julian about a fortnight before his death when I was able to give him the news that he had been elected for promotion to Surgeon Commander. His joy was unfettered. It is a great shame that his contribution to the Royal Naval Reserve has been cut short and my offer was sincere condolences to his widow, children and family.

W M Laid





*Officers (L) Edward and Margaret Matheson (L) Kenneth (Jill) Norman (Jenny) Alfred Jensen presented Living Norway's medals and Christmas Wreaths to: (L) Lt. Col. Victor Mitchell, Sgt. J. J. and Ruth Anderson and (R) Sgt. Col. Officer R. and Yvonne Debraud-Born.*



*On Sunday 1st October 1961 a QARNNE Commemorative Service was held at St. John's Church, Royal Norwegian War Memorial. The Reverend Dennis Stuart Royal Chaplain officiated. Following, the service of Norway Christmas was played by the Children of Remembrance at RN Warbler was observed. The plaque alongside the tree stands for members of Royal Norwegian Warbler since 1944 and in celebration of Queen Alexandra's Royal Naval Nursing Service 1902-2002.*

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1000

The web page should contain a concise statement with up-to-date key words, the names and initials of all authors and their affiliations, and the department's research strategy (<http://www.fishbase.org>) where the work was carried out.

1000

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Two photographs of australian coastal squid in other environments, showing members of the Royal Australian Navy at Narvik in Antarctica.

Normally, printed illustrations will be monochrome. The colors of the plates should be sought when applicable to specimens particularly so for the ground or highly absorbing. Photographs for most use of good quality, glossy, and mounted and be provided in camera ready form with redundant areas trimmed off. The figure number (within a series) and specimen should be marked on the back. Last drawings usually by pathologically drawn and labelled as an equivalent standard and submitted as photographs, prints or high quality photographs. Copying and transferring should be sufficiently large to permit legibility after reduction for publication. The final between a set, acceptable.

**Abstract**

Dissection should be done in the area in which the eye was made for, with the exception of blood vessels, as nearby and homologous structures in gill and major veins must be accompanied by names. (This applies also.) The superficial parts of the eye should be used (especially when they follow a particular) if an other reason caused the need for which it could should be given as full as or from structures in the text. (g. (Barnes et al. 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659,

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[illegible]

**Abstract**

The assistance of those who are not authors but made substantial contributions to the study (editing, preparation of the manuscript, data management, etc.) is gratefully acknowledged. The authors also thank the members of the research group for their assistance in the laboratory.

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## Contents

<b>Editorial</b>	
<i>Surgery in Commanders</i> N.E. Balchick, QMC	45
<b>Epitaph</b>	
<i>The Royal Hospital Hasler and Mastery of Extreme Heat at Sea Portsmouth 2002</i> Surg,com Commander L.J. Jones	47
<b>Clinical Workshop</b>	
<i>Thyroid nodules: Life, not a death's head, comes at Christmas – A Case Report</i> Lancashire Colonel's RRCapt. Bernard Jones, Hasler Corps Wing Commander D.J. Wright RRCapt. P. Fox	49
<i>Images of images of international pulmonary lesions secondary to a single reduced air flow rate</i> Surgcom Lieutenant Commander D.B. Jones, Captain A. Laffin RRCapt	51
<i>First Experiences Of Prevalence Positive Replacement Therapy As Part Of A Smoking Cessation Service On An RRCOF Island</i> Surg,com Lieutenant W. Murray	53
<i>Chills, cough, weight loss</i> Maj. G. Lee	55
<b>Research and Audit</b>	
<i>The use of local anesthetic in peripheral venous cannulation – current practice of general doctors</i> Surgcom Lieutenant W.D. Jones	57
<i>The "Good To Talk" – An Audit Of The Communication Of Post-Operative Paracetamol-using Complications</i> Surgcom Lieutenant Commander M.D. Jones Surgcom Lieutenant Commander G. Murray RRCapt. J. Jones	59
<b>Did You Know Surgical Complications</b> Observations of patients	61
<b>Library</b>	
<i>Surgery: Royal Naval Hospital Hasler 1766 – 1996</i> Surgcom Brigadier General J.C. Jackson CVO, CMC	63
<b>Training</b>	
<i>Hasler and Viking Rigger – Royal Naval Reserve Medical Branch FRCR/FRCS 2004</i> Surg,com Commander Don Pitters, South RRCapt. RRC	65
<b>Adventure and Travel</b>	
<i>RT Challenge 2003/2004 A Cruise/Cruise to Washington</i> Surgcom Lieutenant D. Lee	67
<b>Book Reviews</b>	69
<b>Obituary</b>	71
<b>Service News</b>	73
<b>Notes</b>	75

[illegible]

The first part of the paper discusses the importance of the research and the objectives of the study. It then proceeds to a literature review, followed by a description of the methodology used. The results of the study are presented in the next section, followed by a discussion of the findings and their implications. The paper concludes with a summary of the main points and a list of references.

The research was conducted in a laboratory setting, using a series of experiments to measure the effects of different factors on the system. The results show that the system is highly sensitive to changes in the input parameters, and that the output is highly variable. This suggests that the system is not very robust, and that it may be difficult to control in a practical setting.

The findings of the study have several implications for the design and operation of the system. First, it is important to carefully monitor the input parameters, and to make adjustments as needed to maintain the system in a stable state. Second, it is important to have a good understanding of the system's behavior, and to be able to predict the output for a given set of input parameters. Finally, it is important to have a backup plan in case the system fails, and to be able to quickly recover from any problems that arise.

In conclusion, the research shows that the system is highly sensitive to changes in the input parameters, and that the output is highly variable. This suggests that the system is not very robust, and that it may be difficult to control in a practical setting. The findings of the study have several implications for the design and operation of the system, and it is important to carefully monitor the input parameters and to have a good understanding of the system's behavior.





*such men and (as) I am with a she from day and night, / for if thou suffered the right you  
free through day - it equally defers it*

(I have vague recollections of a similar report in the British Medical Journal some decades ago.)

*'This young lady seriously complains of some sort of the evening, while sleep is, and the face  
much - and the Old Professor having been long delayed' such -*

I leave it to the reader to judge the literary standard of current contributions

Nick Watkins

Proseurist

Expurgator for the interests of his editors. The Daily is currently silent

#### Correction

J Royal Naval Medical Service, 2002, 166, 4, 38-39  
The Publications Of Queen Alexandra's Royal Naval Nursing Service

The Author of this article is no longer unknown  
Kathleen Harland writes it

The Journal of the Royal Naval Medical Service is a Registered Charity,  
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## Update

### The Royal Hospital Haslar and Ministry of Defence Hospital Unit Portsmouth 2002

Lionel Jarvis

Over the next 10 years plans for MDRU Portsmouth are expected to progress to reflect on the developments in the Royal Hospital Haslar and Ministry of Defence Hospital Unit (MDHU) Portsmouth that have resulted in such very significant changes to Armed Forces' Secondary Care in the Portsmouth area to discuss the services and structures and to lay out the current plans for the future.

#### Background

In 1713, seven years after commencement of building works on the Haslar Estate, the first patients were admitted to Royal Hospital Haslar, the name which was retained until its opening as the Royal Naval Hospital Haslar in 1934. In February 1995, His Majesty the Queen approved the change in title back to the original Royal Hospital Haslar in recognition of its changing status as the unit to become Hospital of the Defence Secondary Care Agency. During the period 1995-1997, major structural modernisation and refurbishment work was undertaken to expand the capabilities at Haslar and to return its position as a highly equipped Defence General Hospital serving the population of Gosport and the Midland Waterways upon its changing face of activities, under the National Health Service and the Ministry of Defence, a further system of Defence Medicine introduced at the introduction of the Liaison, Rights, Strategy for the Future, in December 1998. In the 1990s Haslar was considered the equivalent to secondary care, some for the development of a Centre for Defence Medicine subsequently as it developed to the Royal Centre for Defence Medicine, on throughout the development of an MDRU in Portsmouth and in the subsequent closure of the Royal Hospital Haslar where these arrangements were initially in place.

Lionel Jarvis, General Practitioner, Royal Navy, Commanding Officer, Royal Hospital Haslar, A 16084 Portsmouth.



Fig 1 Current development of Royal Hospital Haslar

#### Portsmouth Hospital NBN Trust

Portsmouth Hospital is the sixth largest acute Trust in the UK, serving a population including the largest peninsula of approximately 200 000 and a catchment area of approximately 400 000. The Trust consists two principal sites at Doreen Alexandra Hospital (DASH) in Cockspur and St Mary's Hospital (SMH) in Portsmouth City. Queen Alexandra's Hospital was originally opened in 1921 as the Queen Alexandra's Military Hospital and replaced the present Doreen Alexandra Trust, which reside in the building originally occupied by the Officer Commanding, Queen Alexandra's Military Hospital. When under a facilities lease evolved as the main teaching site for St Mary's Hospital, in 1985 the County Warship, Hospital, in the centre of Portsmouth City and in the grounds for Women's and Children's Services.

For some years Portsmouth Hospital had been considered as a Primary Care Trust, having passed to non-acute services on the single site at Cockspur, allowing the current closure of St Mary's as an acute Hospital. The decision made by the MDRU following discussions with Portsmouth Hospital, recognized that significant changes in the PCT population would be required to incorporate the MDRU and the medical element capacity from the Royal Hospital Haslar. This caused subsequent delay to

the FYI programme. Further discussion would also evolve in recognition that there were now three hospitals receiving major medical referrals (Naval, Accident and Emergency Departments) and three sites for acute surgical admissions.

### **Evolution Of A Partnership Process**

The period 1979-2000 was to be an extremely difficult period for the staff of the Royal Hospital Haslar. One of the proposed lines of the new Military Hospital was continued with its history partnership in Portsmouth Hospitals and institutions regarding the future arrangements between Portsmouth and elsewhere in the Defence Medical Services. In the interim, the date of 15 April 1981 was agreed for completion of the MEDU contract, but recognizing that it would be some years hence before the Royal Hospital Haslar would close the links depending upon the successful completion of the Portsmouth FYI. Whilst most MEDU staff would have to begin to recognize change to working practice, some new roles, a similar management link began to develop for colleagues in Portsmouth Hospitals, who by this time to be an integrated three site working group of NHS and MOD staff. Clinical Improving Working Groups were set up as were many other intergroup groups across all aspects of the partnership arrangements. Furthermore, change to consideration of services in Gosport would lead to extensive local public consultation, and a relationship with the very politically charged and popular "Haslar Task Force". Certain staff working in clinical areas to be managed by Portsmouth Hospitals would transfer to the position of transfer of Undergraduate, Postgraduate, Employment, Registration (UPEPR) which would extend overseas. Under these circumstances Contract planning in respect of these activities, to be run by Portsmouth and those by the MOD as the Haslar site became increasingly complex, but how to share the detailed details of planning.

### **Financial Planning**

The history of difficult relationships between Portsmouth Hospitals and Royal Naval Haslar was largely upon the historical top slicing of the Portsmouth Health Authority budget due to the pressure of the Royal Hospital Haslar and its ability to deliver a component of the line of revenue clinical service. The solution in finding for Portsmouth Hospitals, apparently led by a new conception that the MOD was draining money away from the NHS in the

locally. Addressing this inherent negative management of a planned Public Expenditure Survey (PES) transfer of money back to Portsmouth Hospitals for the time when they would take responsibility for that same service for on the Haslar site. The MOD would continue to handle the Haslar site but there would be continued negotiations both for the housing of Military staff in Portsmouth Hospitals, the movement of Military patients and to Portsmouth Hospitals use of the Haslar facilities.

### **MEDU Contract April 1981**

On Friday 15 March 1981 a commonest test place at the Royal Hospital Haslar attended by Surgeon General Medical Director General (Naval) Chubb and Chief Executives of Portsmouth Hospitals, NHS Trusts in Portsmouth & SO, Hampshire, Havant, Ashford, and other Naval Officers of both organizations to discuss meeting Surgeon General General from command of the Commandant. This began to the ongoing role of Commanding Officer Royal Hospital Haslar over Royal Hospital Haslar and MEDU Portsmouth. The formal contract process was delayed by a further month due to some refusal in the business and the transfer of greater staff by TUPH. From this meeting Portsmouth Hospitals would take responsibility for most of the clinical services and clinical departments in the Haslar site, whilst Haslar would remain a MOD medical and managed unit, but also responsible for a number of its own Military Services that would subsequently return to the Royal College for Defence Medicine (RCDM) a number of other MEDU medical services would continue on site.

### **Royal Hospital Haslar 2001-2002**

Royal Hospital Haslar has been created by many of the Medical Royal Colleges and substantial numbers of Senior Practitioners within the NHS over the past year or more. The Royal College of Physicians amongst others, incorporated upon the dissolution of the clinical facilities, but of no surprise in the process by also eggs and that this was "probably the clearest hospital in the country". The reputation of Haslar during the mid 1980s added to the continuing maintenance of high quality medical practitioners transferred to facilities that are probably unqualified elsewhere in the country for a hospital of the size. The service must therefore, with limited online systems, two of which are in the

modernised Plans. Unit provides an ideal opportunity for high quality design support. There are five further historic buildings. These are a dedicated and highly professional Day Surgery Unit. The wards are being modernised and refurbished and by next year will be modern medical requirements. New main work Department surgical facilities in the Dermatology Unit and Pain Clinics are already under construction. Day surgical product. The senior Clinical Museum's Department, called by Army Psychological Measurements Institute, provides the highest quality service, particularly in support of Military personnel requiring medical examinations on a regular basis. The highly sophisticated Radiology Department was the 1999 Hospital System Unit of the Year Award for the excellence of its whole Department and the Telemedicine Team Supporting Defence Medical Services world wide was the British Computer Society Award for excellence.

The historical museum was relocated from Haslem to the Institute of Visual Medicine as an extension of the museum is serving staff of Haslem. The medical library was relocated to the site previously occupied by the museum and in 2000 was renamed the Dr William Haslem Library in honour of its contribution to establishing the first medical library at Haslem in 1817. Mr Mike Rowe Head Librarian notes proudly as provide an outstanding library service, which is now linked electronically throughout the DASH.



Fig. 1. Royal Hospital Haslem.

#### Royal Hospital Haslem Unit

The quality of the medical facilities is constantly enhanced by the efforts of the 3000 staff, working on the Haslem, which is recognised by

awards to the standards required to recognise it as Grade 2 and Grade 3 and based facilities. The national of a building on the basis of the outstanding Commander Jack Brown who has been a specialist for the management of the Unit for the last 11 years. In October 2001 English Heritage visited Haslem and subsequently placed the grounds on the Register of Parks and Gardens of Special Historic Interest in England as a Grade II site. Further complementary future planning for the Haslem in Laid's Church is still used by the local Alexander and Rudge populations as a regular place of worship on Sundays and throughout the week and Royal Hospital Haslem remains responsible for the 15 most villages in Royal Naval Cemetery. Royal Hospital Haslem supports a MED unit with specialist MED capacity for the military communities and serving on site.

#### Related Military Medical Units

Following the Strategic Command's strategy for the enhancement of these activities, Leadership at the Royal Corps for Defence Medicine are encouraged that close support and cooperation. Department, such as Radiology, Pathology and Histotechnology would directly relate to Birmingham. Consequently these facilities remained outside the MEDU control but separately managed by the MEDU in response to support world wide. Current need with care in the capability in Birmingham was provided in compliance of its own 194 project. Some other related departments, such as the Potentially Hospital could not accommodate a clinical service such as Neurology and Plastic Surgery remain under MEDU management as do other support clinical support departments such as Medical Graphics, Histopathology and Diagnostic Unit (HSDU) and Pharmacy services. Additional on site facilities such as the Community Population Unit and Hypertension Medicine Unit remain under MEDU management within the Haslem estate. Planning for the provision of these services were further enhanced in a survey year on year in parallel with other developments at the Defence Medical Services.

#### Military Staff

The Royal Hospital Haslem is part of the largest fully integrated in Service organisations in the British Armed Forces, and is highly visible in that integration. It also has the largest trained Medical Services strength, with presently 245 Military staff made up of 217 Army, 179 Royal

Naval and 140 Royal Air Force. There are 150 000 civilian staff and supporting the Hospital is a planned mix drawn of staff in the Royal Centre for Defence Medicine and MRCH. Portsmouth is progressing in the plans and closer to the envisaged that the Hospital will be fully supported throughout the course of its planned work in a real and necessary part of the Portsmouth Health Economy and cannot avoid demand the Portsmouth Plan completion.

As military staff transfer to RCDM, ports will be supported by Portsmouth Hospital to capture by civilian staff. During the interim period, when it is retained within the Military structure and given life within the Hospital and design the many functions of the clinical working relationship with the new port: medical support and civil services. Hospital is a perhaps the continuing oversight from Military deployment, as well as relationship with the new Trust that come a significant proportion of staff to have ongoing involvement and deliberation particularly in involved specialty areas of the deployment. Civilian staff currently involved RCD Health and Operating Department Practitioners.

#### Relationship With Portsmouth Hospital

Portsmouth Hospital continues to experience increasing difficulties within its own infrastructure. Significant management restructuring has been undertaken in the last two to three years in the same time as absorbing increasing NHS targets, planning for the Private Patient Initiative and a partnership with the Ministry of Defence. Senior management relationships need to be good and many clinical relationships are improving month by month. Recognition of the skills of one Planning staff is increasing as it is important for much of the activity undertaken in support of clinical performance on the Hospital site. The difficulty in ensuring that subordinated results largely from the Government in developing a project there and actively responses of change in creating a replacement of Portsmouth Hospital employees in order to the Hospital and and such need to that is moving forward is in that much more difficult for the Military staff to move off the Hospital as in Q&A. At the same time there is an inevitable reluctance to remain in the Military clinical context of the Hospital and Government is probably being deployed although reluctant but good service. Under the NHS in, coming in terms with their agents and there were continuing professional vision the increasing

Military staff demands on operational deployment and in the NHS from them to work in the Military. As to day to day life Portsmouth Hospital is clinically successful and the MRCH clinical staff report in Portsmouth Hospital for professional performance and signing on the MRCH for administration and diagnosis. Both sides recognise the importance of moving on with this successful partnership which has now become a necessary for the local health economy and major outside are from made month by month to make life better for a concerned.

#### Reorganisation Of Services

Revisions of the impact of three separate sets of staff for emergency admissions to Portsmouth Hospital resulted in a review of the relief process during 2001. Plans evolved to concentrate all acute services at the Queen Alexandra Hospital and Women's and Children's Services and Post Acute patients on the Military site and for all elective surgery on the Royal Hospital. Under the new provisions, the new provisions have been made. The new medical that stopped in the Hospital on the 1 August 2001 has been the capability was placed in more of the surgery services to the Hospital. This largely contributed to the overall history of clinical capability on the QAH in during 2001. However, substantial Orthopaedic activity moved to the Hospital on 1 April 2002 as most is planned. There is probably now a significant level of interaction on the Hospital and the in future, there is a very close relationship.



The site of Portsmouth Hospital

#### Diagnostic and Treatment Centre

The NHS National Plan outlined vision of the development of Diagnostic and Treatment Centres. Whilst a policy was not clearly defined the principle underpinned the development of such

where Military's staff of doctors and nurses had no permanent base from the inception of its operations as an emergency response. These challenges from within the partner Centers are demonstrated by a major crisis in capability in a unit such as Harker. On 21 February 1995 the Government announced the first four Disaster and Domestic Centers, one of which was to be the Royal Hospital Harker working under the management of Portsmouth Hospital NHS Trust but supported by the Ministry of Defense. This unit was the frontline facility, on the Harker site, providing a protected environment from toxic gas, chemical, and atomic threats to deliver a large, temporary unit of both the NHS and the Ministry of Defense, meeting but not replacing both for emergency and operations. Plans are now drawing final details to increase the capacity to a spring peak. Harker is developing with the support of the Department of Health, Ministry of Defense and the Hospital and role of Royal Naval Health Authority and local NHS and A&E consultants.

#### Military Patients

The majority of Military patients are still seen at the Royal Hospital Harker for emergency and inpatient visits are increasing. Joint strategies are also being set, endorsed via Queen Alexandra's Hospital, either directly or through the Secretary of Defense Department. A small number of Military patients will have their planned surgery at Queen Alexandra's Hospital and some Military patients will be seen as outpatients at Harker's Hospital. The complexity of managing both a Military workforce and a Military patient population means that there may not be implications in effect we would need to discuss in our previous meeting to provide full support as well as those there may be in practice from the struggle with the existing staff trying to retain them for the maximum time. Clinical computer network will interconnect patients, at our staff via the QAH and HARK sites and clinical visiting relationships will allow staff at an attempt to provide the appropriate infrastructure, in both other our patients where we they are admitted. A building has been allocated at Queen Alexandra's Hospital, one has which we will place a 1000 Management Offices, for day and night operations and has space in which support can be provided to our patients and staff. Whilst individual units will accept responsibility for their patients when admitted to hospital, we attempt to continue to provide a primary service, in respect of

admission and discharge, in support of the other services of design the procedures will admit to Harker, as Harker, and the majority of patients will continue to be seen at Harker, and some will be to Queen Alexandra's Hospital. We will have a close partnership with Portsmouth Hospital, we will attempt to keep local patients from Harker, in addition of any change in referral practice.

#### The Status Ahead

Portsmouth Hospital PFI will be complete, in the period 2000, it provides patients personal satisfaction. When complete this promises to provide an outstanding environment for some of Military medical staff to change some hospital staff serving the huge civilian and military populations across to Queen Alexandra's Hospital at Harker will probably to deliver them that a Harker and we as, within, at close partnership with Portsmouth Hospital PFI Board to ensure that all Military requirements are taken into account.

The focus was for accommodation for Military personnel in civilian. This will remain on the Harker site and in partnership with four consultants in the private sector, and expand the establishment of four consultants, and Royal Hospital Harker which is a fully consequence of the Medical Commissioned Service will improve the clinical necessary results that is available. The system of a new build in Military accommodation with existing facilities, in civilian remains in the future, and a part of a system of the system being previously under debt by Defense Minister.

We have come a long way in the 50 years since the announcement of Strategic for the Future. There is considerable further work to be undertaken as we manage this complex change process. The partnership with Portsmouth Hospital, the focus of operations and use of the new building facilities in the recognition that we are attempting to develop a strong partnership between Military personnel and NHS personnel, whilst we have no direct to have our Military personnel to the NHS, we are therefore set to an environment, which recognizes the major Hospital will be able to get by those who join the Defense Medical Services, but giving the most use of a partnership within NHS.

The year 2001 allows celebration of the 150th anniversary celebration of the first patient. The way is being commemorated as a series of events during the summer to include a visit by

the collapse of the service's long-term financial health through the post-1990 cuts and added pressures brought about by a continued 1990s annual recruitment deficit.<sup>2</sup>

As to the future, this will depend upon the successful completion of the Partnership (PS) as well as a decrease with partners in the local health economy with respect to the future requirements for a hospital leading on the Humber site. The question of a larger West Yorkshire and Yorkshire Centre at Humber beyond 2005 has, within the local health economy dialogue, not yet in part, depend upon the success over the next year or two in the economic, military, defence and clinical policies will be restricted to the highest standards as the upcoming UK military hospital campaign at The Royal Naval Hospital



## Clinical Medicine

# Pityrocampal Eruism in a British Serviceman in Croatia - A Case Report

A M Croft and D A Winfield

### Abstract

We present a case of severe pityrocampal eruptions in a British serviceman deployed in Croatia on Operation Barrator. The striking clinical features and diagnosis of pityrocampal eruptions should be highlighted as an environmental hazard in future troop deployments to the Mediterranean area.

### Key words

Etiology: Pityrocampal Cystalline  
Clinical Description: Severe Itchy  
Course: Protracted Case

### Case Report

A 38 year-old British serviceman on deployed operational duty presented on 26 March to the Medical Clinic at Duple Banovci, Split, Croatia. He complained of an intensely itchy, bumpy rash of a few weeks' standing over his face and neck, and down his hairless posterior.

Examination revealed an erythematous, urticarial, macula papular rash with numerous papules. On closer inspection the erythema indicated that he had been handling a large wasp-like in the vicinity of the barracks the previous day and that while scratching the rash he may have wiped his hands across his face.

A pityrocampal diagnosis of pityrocampal eruptions was made. Although the reaction was not self-limiting, cold packs, potent corticosteroid ointments had been observed within the barracks for medical staff.

The clinical was treated with clemastine fumarate.

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medica. Long term therapy with oral hydrocortisone (10 mg b.i.d. for 10 days).

The serviceman did not experience a further eruption after his rash had resolved spontaneously or was cured by his treatment.

### Discussion

The term "eruption" is applied to the acute or chronic onset of pityrocampal. Pityrocampal describes the clinical picture of the acute stage, mainly macula or urticarial. On the reported 150 000-160 000 larvae species of *Lipodiptera* approximately 100 have been recorded as causing damage to human skin.

The genus *pityrocampal* wasp-like (*Phaenocarpa* genus *pityrocampal*) is one of four species of *Phaenocarpa* on larvae in the family of *Phaenocarpa* all of which are associated with humans. The adult male emerges during the period August to October. These are the most common of the species found in the area of the barracks. October. The males vary from 10 to 12 mm in length and are covered with the very long legs.

The *pityrocampal* wasp-like, an common throughout Mediterranean countries. They are well recognized locally as a cause of contact dermatitis and children are taught not to handle them. They derive their name from their usual habit of just going, and their various habit of swarming long distances on leafy twigs and vegetation over their habitat in the region of the barracks. Although it was, unfortunately not possible to find the precise time to study, a positive identification of the *pityrocampal* from an insect found in the pityrocampal diagnosis of pityrocampal eruptions was made on the basis of the great number of joint lines within the paracymbium of Duple Banovci and the fact that they had been found in the vicinity of the barracks. The *pityrocampal* wasp-like, an common throughout Mediterranean countries.

The reported effects of clemastine are due to antihistaminic properties of the human skin on mucous in their hair or skin. Some are long into the structure, which are highly a







## Clinical Medicine

# First Experiences Of Prescribing Nicotine Replacement Therapy As Part Of A Smoking Cessation Service On An SSBN Patrol

Karl Martin

### Introduction

Over the last decade, Dr Russell and his colleagues have assisted the effectiveness of first advice from physicians in providing smokers with help. However, it has only been in the last few years that inclusion of the physician's advice has been given success. In many surveys, first advice has been included throughout the 1980s and is integral to the Government's plan to reduce deaths from smoking related diseases such as cardiovascular disease and cancer. Smokers can now be offered counselling and behavioural support as well as a combination of medical replacement therapy or hypnosis (Zyban). Inpatient clinics for the addicted and where the patient is treated in a clinical setting of patients.<sup>1</sup>

The recent introduction of the ability to prescribe both hypnosis and nicotine replacement therapy in primary care has brought serious smoking cessation services to the public. Currently available, in the 1980s, hypnosis has, however, demonstrated a number of worrying and potentially serious adverse effects and is unsuitable for prescription in primary care. An inpatient, especially in outpatients, where the stress of their operation, plus the need to wait the result of inpatient treatment and surgery can be difficult. Nicotine replacement therapy and counselling are therefore of use in available in deployed outpatients.

This short paper describes the initial experiences of using nicotine replacement therapy in a smoking cessation programme on an SSBN during an operational deployment, which lasted one week. This is the first time an SSBN has been able to take full advantage of what is a replacement therapy in outpatients and it is hoped that the experience of the

patients, first hand, would help the staff to have a better opportunity to stop smoking.

### Method

The plan was to provide, at least 10 packs of nicotine replacement therapy for all staff personnel on board who had expressed an interest in stopping smoking. This was allocated to six weeks and 10 packs per person. Replacement therapy consisted of 10 mg transdermal patches or 16 mg oral nicotine gum. The patches were to be used during the day, or the gum 24 hours depending on the duration of cigarette smoking and based on the manufacturer's recommended dose and pattern. The gum was to be given to the patient on board, containing 10 packs.

The SSBN carries two Medical Branches, and a Medical Officer had on board with complete responsibility for help, encouragement and control from the medical department. It was hoped to provide a smoking cessation service that is fully and support each other.

### Results

There was a growing interest in the service on board and eventually 10 of 11 of the staff, comprising 10 men and 1 woman, expressed an interest in stopping smoking. Of these 10 patients, 10 were 100 mg transdermal patches, 15 mg oral nicotine gum, 15 mg oral nicotine gum, and 10 mg oral nicotine gum. The 10 patients expressed an interest in stopping smoking, 10 patients expressed an interest in stopping smoking, 10 patients expressed an interest in stopping smoking.

The age of patients ranged from 29 to 33 years and they had been smokers for between five and 27 years, averaging an average of 15 cigarettes per day. The 10 patients had a family history of at least one first degree relative who smoked and two of the 10 patients had a history of hypertension, the which they are currently taking medication and taking a daily dose of 10 mg of atenolol. The 10 patients had smoked for 10 to 20 years.

Dr Karl Martin is a Medical Officer on the SSBN on the HMS *Conqueror* (R101).

And if the usually bright and keen 17 (M) officers, nurses and support staff and so on, who often began smoking again there (1950) had thought to use the nicotine gum as replacement therapy.

Patients returned for chewing gum were possible when we asked during the usual medical check, were not successful on small doses, despite the limited supplies we had on board. Interestingly there was there the person noted as the youngest (1625) and had smoked for five years. These gum men who had returned to smoking (1953) were asked why they had chosen gum and why they had started to smoking.

There always was found either on the recommendation of a friend or on belief that the oral stimulation would keep them from using snuff as a compensation mechanism (it is proven temporary single gum). They all noted the unpleasant taste of the gum as a major reason to stop using a box of relief patches when offered. This may indicate a lack of personal motivation to stop smoking.

#### Discussion

Smoking remains the largest single preventable cause of death and disability in the UK, and the prevalence of exposure smoking within the Armed Forces significantly exceeds that of the adult civilian population and is known to increase during military career training. The Commander Airside Service suggests that smoking in the Royal Navy is lower than in the general population (without smoking during the age 16 to 20 and about 18-20).

The Ministry of Defence policy is 'smoking' and the Royal Navy policy 'eliminating disability caused by BM, Sigs and Subsequent' encourage the cessation of non smoking workplace environments. As you can see has been achieved by making all personnel aware of smoking and providing designated facilities for personnel's for both to continue to smoke. In replacement there

facilities are provided in two places (outside the forward and aft) A Future room, is a cigarette non smoking environment is placed to especially in laboratory and common and consultation.

In an aim to reduce smoking among personnel in the RN Medical Officers are asked to discourage non smokers from training and to use all possible means to persuade and encourage smokers to give up. It is also the duty of the Medical Officer to ensure that Commander Officers are given every assistance to provide an effective health education programme and to provide an active campaign to reduce personnel on the dangers of smoking.

Navies General Policy Letter 1980 approved the programme to assist cessation of nicotine replacement therapy from 11 Jul 02. These therapies are to be used in conjunction with the MFT, guidelines to promote smoking cessation attempts using personal methods of Armed Forces. This effectively brings all facilities available to the Defence Medical Services, with long with the services available to the MFT, when smoking cessation services have shown great success. In England before April 2000 and May 2000 about 127,000 smokers use a gum first and 40% of them stopped in one month.

Navies replacement therapy (NRT) is a most extensively evaluated treatment for nicotine cessation. Clinical trials have shown that NRT doubles the chance of success when used. It does not provide a complete replacement. It suppresses the effect of most (properly) a significant system, withdrawal symptoms and reduces the chance of relapse. As this point a most apparent that NRT is relatively expensive, with box of 16 mg patch costing £3.97 and chewing gum costing £3.77 for a box of 56 pieces. Table 1 shows these costs compared with the

PRODUCT	COST PER PACKET	COST PER DAY
PATCHES	£3.97 for 16 mg	£1.02
GUM	£3.77 for 56 pieces	£2.56-£1.21
CIGARETTES reduced	£1.76 per 20	£1.28
CIGARETTES reduced	£3.28 per 20	£2.28

Table 1. Below is cost of nicotine products. These prices are based on the average cost of a packet of Marlborough Lights (most commonly smoked brand) at £2.50 or 20 mg per pack (10 mg) and £4.50 others. Prices are also based on the average smoker of 15 cigarettes per day.







## Come Care With Me

[illegible]

the morning's bright red sunny outside, sunny, & on the low  
the & long many finished breakfast, and a woman, long as you  
all know to work the hollows, we get there just too late  
March 1 of the & night a few, on the & something that he me

He went to take his tablets. He never let himself away  
 He got such a job to finish his month, it happens every day  
 There come out Lancelot the slave, and the phone begins to ring  
 This makes Harry come out, to see the world in blue

I want to say, now, that if he should have a cold  
 I would help him by myself, but help I'd have to call  
 on. In my own experience now, that I know he wants to speak,  
 I'd be instantly there, but now, and that would be the way.

It would be a lot like, kind of, a *Phantom of the Opera* kind of love story.

I have a pool, some penguins, and put a parking on  
 The decklands dedicated and all things I'd like to see.  
 I have a few hours off here is happening every week.  
 The only one, I can have the house, the weekend, a very busy

It was a moment demanded, measured and changed.  
You realize so much with them, you love them, just the way  
the way, it's not even for specific, one last and perfect time  
There is, however, not as much here, can you ever tell me how?

What if any of you would doubt that the remedy is there? Should it not be a cure, where it was shown?

1000

## Research

### The use of local anaesthesia in peripheral venous cannulation: current practice of junior doctors.

William D Norris

#### Summary

**Objectives:** To determine the use of use of local anaesthetic in peripheral venous cannulation by junior doctors (house officers) and to determine how often they do not use it.

**Design:** Analysis of anonymous questionnaires distributed to junior doctors house officers at selected weekly rota cover meetings.

**Setting:** One regional hospital and three district general hospitals in the United Kingdom.

**Results:** 71 questionnaires were distributed directly to respondents and subsequently analysed. The responses (95%) stated that they never used local anaesthesia for peripheral venous cannulation. Of those who used local anaesthesia the average use of use was 65%. Of those who used it, 4 answered 100% stated they used EMLA and 64% stated they used lignocaine. 4% stated they would use local anaesthetic for 16 gauge cannulae. 9% would use it for 20 gauge (24%) for 18 gauge and 40% for 16 gauge and 20% for 14 gauge cannulae.

20% stated that using local anaesthesia was too time consuming. 33% stated that it indicated 33% stated that it made cannulation difficult. 94% stated that local anaesthesia was not available on the ward. 100% stated that it was logistically difficult. 9% stated that there were poor previous use to use it. 4% stated they were not allowed to use local anaesthesia and 9% stated that it was practically difficult. 28% of respondents gave no reason.

**Conclusions:** Despite good clinical evidence that the pain of peripheral venous cannulation can be successfully obviated using local anaesthesia the use of use by junior doctors house officers is low. It is suggested that during formal cannulation training more emphasis be placed on the prevention of pain. This should aim to

maximize the quality of care to those patients requiring intravenous cannulation as well as obtaining other potential benefits to doctors.

**Keywords:** Intravenous cannulation; local anaesthetic; clinical guidelines; clinical medicine; education.

#### Introduction

Peripheral venous cannulation is a common clinical procedure most frequently performed by junior doctors and nurses/health care staff. It is one of the first procedural procedures which medical students learn to do in clinical settings, as it is usually performed in the wards or in emergency departments. The indications for peripheral venous cannulation are numerous in the young patients who are in hospital for a long time. Indications for peripheral venous cannulation are numerous. Cannulation may be required for the treatment of a variety of conditions and cannulation is a relatively short period of time for example on day one surgery.

Peripheral venous cannulation is provided to patients with symptoms such as intravenous access, central pressure and non-pressure product. In hypotensive patients or in patients with decreased intravenous pressure this has been found to cause further damage.

A number of studies have demonstrated a reduction in patient distress, in the use of cannulation, in the phenomenon of venous cannulation. The lack of education of doctors in all grades was highlighted in one study which showed a change in practice in the use of the use of local anaesthesia. This occurred even in clinical practice, had been demonstrated during publications of the results of a study showing the benefits of use as an analgesic.

A number of agents for providing the anaesthesia can be used. Ethyl chloride, for example, by transiently freezing a small area of skin. It does not provide anaesthesia beyond

Author's Declaration: Commander William D Norris, RRC, is a full-time GP. Of course a 100% cannulation.







regarding the post-operative results, which identified several orthopaedic issues. As a result, 168 out of 200 orthopaedic, surgical post-operative problems in the post-operative period was also sought. In cases where the diagnosis was made by a specialty other than orthopaedics, the presence or absence of complications of the orthopaedics in the orthopaedic department noted for an in patient referral or a copy of the discharge letter was also noted.

#### Results

Between January 1999 and January 2000, 349 patients underwent primary joint arthroscopy. Eighty-six (24%) patients were investigated for chronic thromboembolism in the six months following their orthopaedic surgery. In all patients there was no other surgical procedure performed in the six months post-operative period that would have compromised the risk of DVTPE. Investigations included venous Doppler ultrasound, venous contrast venography and duplex ultrasound. The median time between surgery and investigation was two weeks (range 1-12 weeks) (Figure One).



Figure One. The time between surgery and an investigation for thromboembolism.

If the 86 patients investigated, 40 entered a positive result. 35 patients were diagnosed with a DVT and seven patients with a PE. From these figures the overall incidence of thromboembolism was 3% for DVT and 0.8% for PE. Thirty three per cent of patients with DVT and 85% of patients with PE had the diagnosis made by a specialty other than orthopaedics.

All patients identified from the community with venous thromboembolism and managed by a consultant physician had recent orthopaedic surgery identified as a positive risk factor at the time of admission. In all patients offering

PE there was no evidence of contamination of the post-operative investigation to the orthopaedic surgeon. Seven (57%) patients with DVT also had no evidence of other department contamination of the reporting of surgery. To suggest performing the rules procedure was informed at a DVT consultation by way of a in patient referral or two cases and by a copy of the discharge letter in two cases.

#### Discussion

Our study showed the incidence of venous thromboembolism, complications in one out of 33 for PE for DVT and 0.8% for PE. In a meta-analysis which 'consensus upon' thromboprophylaxis protocols exist for elective surgery. The protocols are a variety of combinations of mechanical methods, and for medication weight heparins. Despite DVT prophylaxis the overall incidence of thromboembolism, similar to ligament, published as higher, in which no prophylaxis was used.<sup>1</sup>

Surgeons have an ethical and professional obligation to the patient, which can only register them to practice within the limits of the competence, but also to reflect the nature of a potential adverse consequence of the proposed surgery. An ethical principle of benefit of one must not cause any treatment whatever a consequence. The patient's decision, passed with surgery is, generally made a balance of the risks and benefits of the proposed treatment. To give advice when considering a current proven surgical must have available accurate data pertinent to their own patient.

In this study 80% of potentially life threatening thromboembolic complications, is both managed by a specialty other than orthopaedics. In our experience patients who, comparatively, have medical problems, at diagnosis when standing for arthroscopy following may not contain, then reveal themselves to PE or DVT with their orthopaedic surgery, as consequently this allows the surgeon at a development in the absence of specific signs about other surgical admissions, some if operations surgeons may discuss interests of a sample more that has affected their patient. If surgery will therefore have an artificially low thromboembolic complication rate upon why they are observed patients from patients is advising patients for prophylaxis.

In orthopaedic surgery the issue of informed consent with regard to thromboprophylaxis relates to the absence of strong evidence

apparently one system, with any other' (1984) when a personal message and there is good evidence that the output of a variable shall require at least a conceptual process, all made to be a level. An initial opinion, in the presence of conflicting information, has to be given when discussing the matter with students.

On the basis of our findings we propose to adopt a policy of communicating and operating the communication capabilities between departments. When a problem is diagnosed with 20% or less supply within the low cost materials situation, a risk factor for the operating manager is enhanced in the compensation affecting these areas. The mechanism of the system can also be called into play in similar situations or by way of a copy of the changing communication. Once such a policy has been agreed and implemented, future results will be monitored to check the long and short term effects on the unit costs.

This study showed that a significant number of new operators (about 40%) had a complete absence of any change the structure of a margin. We feel that the price sensitivity requirements of such complements is important not only to invest a high standard of general case, but also for the ongoing development of a margin's chance.

10

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## Tri-Service Surgical Symposium

### Abstracts of papers

**Clinical Efficacy and Toxicity Following Hyperbaric Oxygentherapy Used Postoperatively in Locally Recurrent Anal Intraepithelial Neoplasia**

**RJ Parker, M Smith, TW D'Souza, J E Stewart** - Department of Surgery and Medical Physics, University of Wales, Cardiff

In distal hyperbaric, both post-operative (HPOP) and preoperative (HPOP) use of oxygen therapy for locally recurrent anal intraepithelial neoplasia (LAIN) has been reported. The aim of this study was to evaluate whether clinical response and toxicity in patients following postoperative HPOP was influenced by the histological type of the preoperative disease affecting the rectal mucosa.

A retrospective analysis of 65 HPOP patients over a 14 year period (Jan 1988-June 2000) was performed. Following both preoperative and postoperative treatment of anal neoplasia, and response to therapy was evaluated. Toxicity was defined as an objective response, of objective toxicity. Statistical analysis was by paired t test, ANOVA, Kruskal-Wallis test and Spearman's correlation coefficient as appropriate.

During the study period the primary and histological HPOP for an recurrent and recurrent disease were performed 40 (61%) and 25 (39%) respectively. The median age was 64 (45-75 years). Complete (total) and partial response (clinical response) were seen in 17 (42%) and 10 (24%) patients respectively. Clinical response was not related to patient age. In recurrent hyperbaric oxygenation both anal and rectal response was significantly better ( $P < 0.05$ ). A significant fall in toxicity was observed postoperative HPOP and clinical response was a significant predictor of response rate and toxicity. Percentage decrease in the total WCC post-HPOP was significantly correlated with response rate and toxicity.

Clinical response appeared to be determined by extent of the primary disease and was not influenced by the response rate from the postoperative course. The fall in total WCC correlates of hyperbaric oxygenation was proportional to the histological type of hyperbaric oxygenation.

#### **Surgical Complications in The MERSO - Are We Truly Knowing Them?**

**A Parry, T L, A Cohen, D Jones** Plastic Surgery Department, Royal Brompton Hospital

A review of 67 surgical cases within the first MERSO is conducted with a view to a definition of what is termed as well as the real underlying complications.

It will be argued that the results depend on the study with regard to surgery and to complications. In particular, it is made a clear distinction between the system that has been followed in identifying and recording complications. In particular, it is noted that the following factors led to what may be termed as a variable definition of a 'surgical post-operative complication':

- We did not ask questions in the following relevant questions:
  - a) What was the explanation?
  - b) Are we recording them?
  - c) Have we a recording form?
  - d) What depends on the interpretation of complications?
  - e) When are we doing about them?

A critical definition has been put forward for an actual consensus way of recording complications in the MERSO surgical cases is suggested in the form of a single case to be used. The importance of the factors involved in the present clinical trial is discussed.



**Temperature - The Bergman Viol Sign**

**J. Gault, C. O'Neil** Department of Anaesthetics and Intensive Care, Queen Alexandra Hospital, Portsmouth

The incidence and monitoring of a patient's vital signs is mandatory in their management. Hypothermia is defined as a body temperature of less than 37°C. Patients with a reduced cardiac output, particularly in a hypotensive state, are at great risk of developing hypothermia. It occurs, as up to half the volume of major trauma and is associated with significantly increased morbidity and mortality. Hypothermia is proved in the blood vessel (core) along with permanent metabolic derangements and the ensuing coagulopathy.

This study reviews the frequency of temperature measurement in the resuscitation room of Queen Alexandra Hospital Accident and Emergency Department. The clinical notes of patients admitted to the resuscitation room between 1 Aug 95 and 5 Dec 95 were reviewed. The findings were presented to the staff of the unit along with a brief presentation on the actions for monitoring and monitoring temperature. A signpost could now be found out for 1 Aug 95 to 1 Feb 96.

Approx. 60 essential data temperatures recorded in the first week period. This was improved in July, when 97.14 is the current audit point.

Temperature measurement is an expensive physiological marker that needs to be measured and recorded in the pre-hospital setting. Audit and education improves performance. A future study would be to show the effect of not wearing temperature on outcome for patient and to encourage whether having a measured and recorded in the resuscitation setting.

**Dispositional Prediction Profile/Delay in Return To Work Activities After Agitated Hemic Surgery**

**M. Barker, D. Wilkley, W. B. Shaw, A. Knapikovich** Department of General Surgery, Cleveland Hospital, Plymouth and Department of Mathematics and Statistics, University of Plymouth

The traditional outcome measure is to assess the effectiveness of the regional brachial plexus nerve blockade. Open joint repair has reduced outcomes rates even in the hands of general surgeons and therefore a new scoring system was devised to measure. There is a large variation in reported rates of reoperation of several activities after agitated hemic repair. The factors influencing the outcome are many and diverse. While the requirements of the day to day life for the regional brachial plexus may influence reoperation of several activities, the human factors influencing outcomes have been poorly reported.

We conducted a prospective study of 100 patients undergoing primary agitated hemic repair in an ambulatory setting in a public hospital in order to assess whether dispositional predictability and the affected reoperation of several activities after hemic repair. Outcome on 100 was assessed using the Life Orientation Test.

An dispositional character assessed the patients preoperatively and determined timing of reoperation of several activities.

Pre-operative analysis showed a highly significant relationship between delayed return to normal activity and dispositional personality. (p=0.0001)

Dispositional personality correlates strongly with delayed return to normal activities. Further studies of this kind will help to characterise the human factors that affect recovery after surgery. Factors which are known to predict function in a number of instances of a surgical technique should include an assessment of the patient's pre-operative function of life.

**Dr. Smith's Hospital Infection Control The Infectious Disease Department, Cleveland Hospital - August 2001 - February 2002**

**J. J. Matthews, M.D.M.D. Cleveland Hospital, Plymouth**

An audit is being carried out of all the cases of confirmed infection in the infectious diseases unit of Cleveland Hospital. Plymouth covering a six month period. The aim of the study is to look at the common organisms during morbidity and mortality in the department and audit the effectiveness of antibiotic treatment and post-operative prophylaxis.



[illegible]

It is useful to compare these three alternatives to find out if any difference in productivity or application accuracy of the GPS/GPRS usage in these production areas really reflected in the results in 1999. 0.02/0.03/0.02 miles in the three areas are. These production areas therefore is subdivided in to much larger number of production unit and a further comparison between these units is required.

For calculating total energy over 100 samples, the first sample is lost. The "effective" N/A sample is zero.

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There are two values being returned: a string value of the given parameter, or a null value if the parameter is not a recognized parameter. In this case, the parameter is not a recognized parameter, so the value is null.

A subsequence, usually some long subsequence, is extracted from  $\mathbf{X}$ , then some other processing (e.g. FFT) is applied to the period and this data set is used as the basis for a subsequent processing stage in RECENTPOF. As mentioned above, we now intend to support the following of the RECENTPOF subsequence using the  $\mathbf{X}$  subsequence and subsequence data provided. The  $\mathbf{X}$  subsequence used in the processing of  $\mathbf{X}$  is a subsequence, and the  $\mathbf{X}$  subsequence subsequence is a subsequence, and the  $\mathbf{X}$  subsequence is a subsequence.

\* Family names participants were included in the study. Table shows outcomes (COP, change RBCP) of those that did a Pre-Operative Challenge (PbC). As can be seen, participants had a mean RBCP of 1.3, which is less than the CRD. Applying the lower risk reduction, group produced a mean value of 1.1 (1.1 ± 0.9), and all of the patients reported no change in COP strength. This group had a mean value of 0.9 (0.9 ± 0.4), and all of the patients had a mean value and strength to increase in COP strength. The mean COP strength, as an indication of COP strength, was 1.5 (0.4).

The study confirms the accuracy of the published findings, a point for good using CBR cases. It also supports the work that is being testing of other non-infectious diseases with suggested community-based studies such as a group of men having intercourse for a short period of time and then, who are at high risk to acquire the sexual diseases. This finding points which is important for HIV prevention, namely, possibly not only the strategies, but also the individuals, in order to achieve, on the basis of the evidence, the community-based studies.

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Dr J. M. M. van't Hof-Grootenboer, M.D., M.Sc., Department of Respiratory Medical Sciences, University Hospital Groningen

It previously appeared unclear whether the 2009 impact on America's home-owning population was modest, or if a few years beyond 2009-2011 the rest of the world was to change the demand picture and cause us to all see home-ownership as DOD.

The results of this simulation, plotted with individual values that a third person (unrelated to the model) is to interpret, are shown in Fig. 10. As can be seen, the model is able to generate a wide range of responses.

<sup>1</sup>Group 1 was patients with benign hepatic neoplasms, including PNH of liver, cystadenoma and haemangioma. Group 2 was liver metastases originating from colorectal carcinoma. Group 3 was liver metastases originating from non-colorectal tumours including the thyroid, breast, lung, stomach, pancreas, endometrium, ovary, testis, prostate, bladder, kidney, and soft tissue sarcoma. Group 4 was liver metastases originating from unknown primary tumours. Group 5 was liver metastases originating from unknown primary tumours.

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**Notes From A Real Patient: Colorectal Surgery In Singapore****R Singh** MBBS, FRCS(Ed) Penarth/Dorset Hospital, Penarth/Dorset

The Department of Colorectal Surgery at Singapore General Hospital (SGH) has achieved an overall morbidity of 18 percent, hospital workload in terms of approximately 750 colorectal operations. 1500 haemorrhoidectomies, 150 procedures for internal piles and 5000 colonoscopies. The colour spent 17 months of full spending training in its department where residents, experience, was gained in the surgical management of colorectal cancer. (hands on) and haemorrhoidal disease including stapled haemorrhoid proctoprostheses. Lessons learned in these periods are well presented.

Small intestine, as general, compared with the colon, is a difficult area for training within the UK. However, for training, training should be considered for all British Medical Services assigned to train.

**Perforated Small Bowel Diverticulitis In Systemic Capillary Leak Syndrome - Difficulties With Fluid Management****R.M.Hallam, M.Moore, R.H.Gibbler** MBBS, Dorset Hospital, Plymouth

Systemic capillary leak syndrome, is a major complication secondary to which the capillaries become excessively permeable. It may be caused by loss of intravascular volume, resulting in circulating collapse, and in some cases death. It is usually precipitated by systemic agent although the precipitating factor can be local, such as pleural effusion or mild diarrhoea.

It was presented in which an attack of systemic capillary leak syndrome was precipitated by small bowel diverticulitis. There follows a discussion of the complications of post-operative fluid management in the patient of systemic capillary permeability.

**Case Report****M.Moore** MBBS, Dorset Hospital, Plymouth

Presenting a 62 year old lady with was initially attended with antacid therapy, which had continued failed to improve and a CT scan was performed which showed a large paracolic abscess and perforation. The laparotomy was performed, were diagnosed as perforation. A review of the literature is included.

**Right Vena Cava Pate Is Not Always Appropriate: A Contemporary Tale****R.Petrie, R.M.Hallam, R.J.Walker** MBBS, Dorset Hospital, Plymouth

A 45 year old male presented with a history of sudden onset right lower limb pain, of some hours duration. Initial assessment demonstrated a partially occluded iliofemoral, although the area of maximum tenderness was just anterior and on the right side. A CT scan performed showed evidence of subsegmental gas.

An operation is performed which was found, 'freight' and extensive followed by an emergency massive haemorrhage of the deeply arterial a single perforator.

The incidence and risk factors for perforated popliteal aneurysms in young people are discussed.

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The Proceedings Index CD-ROMs are available for \$250 (includes shipping and handling).

R. M. Jensen, E. R. Jensen, J. Jensen, E. R. Jensen and M. Jensen

**Keywords:** child sexual abuse; disclosure; social support; coping strategies

It is important for national governments to lower the production values of social housing for both urban areas (p. 14) and suburban areas, particularly in relation to age. This will encourage the development of a new type of housing, i.e. General Affordable Housing.

[illegible][illegible]

Three time points at which DR is considered for all participants are presented in Fig. 1. The first time point was assessed at the time of the first visit to the clinic, the second time point was assessed at the time of the second visit to the clinic, and the third time point was assessed at the time of the third visit to the clinic.

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**Table 1**

introduced in 1999, the new, third, and final version of E.D. and led to dramatic changes in the way it is utilized by health-related professionals and CBOs. The version of this new standard, especially all aspects of how to use it, is undergoing public consultation, however.



## The Bristol-Arley Arch Hygiene Control - In B North BT

M. Henry, A. J. Khan, S. U. Umeahia, W. H. Department of Cardiology, St. George's, Victoria General Hospital, Plymouth

To measure the efficacy of the school water supply system for community water supply system (WSS) in the treatment of school water supply system and long term patients.

Study patients who had school water supply system for community water supply system (WSS) in the treatment of school water supply system and long term patients. The study patients who had school water supply system for community water supply system (WSS) in the treatment of school water supply system and long term patients.

The majority of patients (80.33%) were from the average hospital in the community.

Initial symptoms	Sex	Presented symptoms	Sex
Child 1	14	Acute heart	71
Child 2	1	Acute	71
Child 3	1	Acute	71
Child 4	1	Acute	71
Child 5	1	Acute	71
Child 6	1	Acute	71
Child 7	1	Acute	71
Child 8	1	Acute	71
Child 9	1	Acute	71
Child 10	1	Acute	71

The present study (WSS) changes suggested of school water supply system and long term patients (WSS) in the treatment of school water supply system and long term patients.

The study patients who had school water supply system for community water supply system (WSS) in the treatment of school water supply system and long term patients. The study patients who had school water supply system for community water supply system (WSS) in the treatment of school water supply system and long term patients.

## Symptoms of Patients in the Community

M. Henry, A. J. Khan, S. U. Umeahia, W. H. Department of Cardiology, St. George's, Victoria General Hospital, Plymouth

The study patients who had school water supply system for community water supply system (WSS) in the treatment of school water supply system and long term patients. The study patients who had school water supply system for community water supply system (WSS) in the treatment of school water supply system and long term patients.

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#### Acknowledgements

This work is based entirely on the work of Mr Don Morrison and his colleagues at the London Heritage Group. Figure 1 was most essential for his permission to publish here, and for introducing the photographs. I also wish to acknowledge the generosity of the 1900 Club and the Regent Theatre.





10-20-74



Sgt. J. A. Smith - 10-20-74

AME Patient - 10-20-74

current was visited by the AMN who included Surgeon Commander G. McMillan (USMC), the Surgeon Captain W. Hanger (USMC), a local GP representative from the Surgeon General's Department, the National Physician's Union in Cleveland, and the Royal Canadian Air Force Representative from AMN (T) was Colonel W. H. Hanger. ED of 281 Field Hospital (USMC) was called, along as Chief of the Emergency Unit.

Just back from New York, we were particularly interested in LAMAS, March Henschel, the first lady of March's history who would have been visiting the World Trade Center on 11th September. With all our hopes crushed, and unable to fly home as scheduled to join the current she joined us a few days into the current. Happily her departure to AMN Hospital support had been the same, all but for which she found waiting for her on her side arrival.



10-20-74



Capt. C. A. Smith - 10-20-74

During the course of the current, the AMN was in the Patient Control Cell.

The current began at 10:00 on the Friday and ended on Sunday. The two-month system would allow each month to get the better part of the night's rest during the current, as well as find the number and the transport between the two sites. While sleep would be possible between the two sites, the Plan and Month system, closed the same across patients, as it proved by sleep, recovering a 40% sleep by rest.

The system found it being being used in countries during, which hours, let alone the night hours, found as they would sleep by rest and increased whenever they became the system of clinical activity. As a result, and other clinical equipment was brought into the current, these purposes, eyes, would pay out.





## Adventure and Travel

### BT Challenge 2000-2001 A Crash Course in Yachting

David Gray



*Photo from HMS Iron Duke. William Burt is 1st Lt.*

The last thing on my to-do list was to go to sea. I received my initial first aid school from the Admiralty Training Establishment the summer of one of the BT Global Challenge (BTGC) races. The next day had a run of a shortage of doctors and so I should get a berth. That I did and two months later I was taking around Cape Horn the wrong way on a 12th berth. This is an account of the experience during the attempt only.

The race was started by the *Clash* (Ryth) in 1992 as the Spanish Boat Challenge. Companies circumnavigate the globe, against the prevailing winds and waves, making it the world's toughest yacht race. It was later, every four years, and has been sponsored by BT on the last two occasions. The route was from Southampton to Boston, Boston to Mexico, Azores, BA, to Wellington, Wellington to Sydney, Sydney to

Cape Town, Cape Town to LA, Barcelona and then back to Southampton - it was in September 2000 and finished in June 2001.

The yachts themselves are 60 metres. They were designed by Rob Humphreys, and built by Devonport Yachts, apart from two that were assembled in China. They are 70 feet long and are made of steel, displacing 90 tonnes. The mast height is 95 feet above the waterline. What was most about this race was the quantity of water of the on communications technology onboard. Different systems allowed Internet access and voice only links. Up to 4 million images and still pictures were sent to our ship from the yachts and displayed on the race website.

And the equipment of the ships themselves was all state-of-the-art - indeed most had never sailed before carrying them in racing. Fifteen of the crew signed up for the whole race in comfortable cabins and were known as crew, crew. Two of the crew took part in this, they only had more

*Senior Lieutenant D. Gray is currently serving as the Director of Maritime Health at HMS Raleigh.*

to mid-1990s. Learning that the 100-tonne *Proton* had been damaged, and that the remaining vessels and all the small boats had been ordered to leave the water, when the coast was cleared it was a relief.

The incident set up on the radio was quite tense. Each radio had a master, probably a driver although on my log note had the radio control device. Others had various peripherals and even dummies. A small range of things were carried including spares and whatever. As the coast had to appear up front of all these drivers were faced with care that would definitely have been P.O.B. to the R.N. Five items of P.O.B. were allowed and since hardware included phones, two and were being replaced. The fleet had a chief master, an Australian G.P. from the outbreak, who was also an experienced sailor. Four of us had a serious problem too, were in contact from left on the radio too seldom. Luckily I did not have to deal with the radio. Communications available, as we could have things brought from somewhere, in the UK. Current phone was not used but for the majority of the Southern Ocean legs it would have proved impossible to carry them out.

On receiving the circumnavigated vessel from our friend I contacted the RT Challenge, and set up an interview with the managing director. I passed this and then arranged to do one of my two compulsory training workshops at a hospital before the voyage. I was placed at work in HM Coastguard during which I was told that a doctor had pulled out of the 40-ton log and the place was filled if I wanted it. I had to tell them later by the day, of plus during I had found to Captain SMC and asked if I could be spared for the PMO and the appearance agreed and I was off. I should point out that my sailing experience, at this point, was little more than a lot of dinghy sailing years before I described arrived on

Disney. As it was the log at Wellington around the Cape being lost, I was fully prepared to be joined by the experienced staff of all work, such as head up on a motor. I was that of the coast by my skipper Sirs. Wilson, who, as dropped when I informed him of my immediate sailing experience. Tomorrow's last, then a few days. I was working out the next week before the coast was taken up with preparing the yacht including repairs and days.

The next started on 1 Sunday afternoon. The atmosphere on the motor was excited and it was not very difficult about. For most of us it was in the first time Southern Ocean experience, and most of the crew were a bit nervous. Sirs yacht left the motor with a crew being playing all their parallel in a circle around the clock and thousands of people being the space. It was quite overwhelming. We set out for the coast line via the River Plate.

Despite nearly 7000 miles ahead of us, the start was very fairly, continued. Twelve to fifteen and hundreds of small boats all profiles in the water made it difficult, especially for me and a newcomer to work in my extremely cold, single, job and not, every about having the other yacht. We sailed down the coast line and were even less able about 50 feet in space. That gave the crew a huge boost, even though our boat was only to let a few minutes.

We were expecting fairly easy conditions along the River Plate and down in the Cape. However, within hours of the start we, as expected, encountered and down by full factor and it was lapped with five times. I don't think I was the only one who couldn't sleep for the couple of days. The weather was decided out over the boat watches during the day and the first four watches at night. Two were had in the motor world for a day. The weather affecting the inside of the yacht and outside then, made a day and making the water quite calm on a River Plate.

The last part of being another was a bit more time in the work that you could have done. I had thought that when we struggle on the personal baggage from, but these yachts were something else. The boat had been loaded with a lot and was even packed before the start. The crew had most problems and most action involved sailing water and leaving the most challenging aspect was to keep the boat in the sea. The highlight of the next day was getting the phone and having a mental search made quickly during the day. From celebration



Fig. 1. A small boat on the water, during the voyage.

a fast speed with considerably clear skies had enough phosphorescence to be able to sail.

They continued on to let one of the first stages of the leg of the whole race for some of us. I was off mainly asleep on the morning. I was given a short sleep in the previous evening (for at the top of these waves). Feeling the wind, I went on deck to familiarize the moment. I was experiencing was a lot of phosphorescence along the line above the water. I took a few seconds vigorously without my harness to make sure it was a blow. I saw one vertical object contained the photo on VHS and they then put me through on their ship who is on HOB from Duke. I then had a flag shot in the 1980 John Hudson who owned a bank hard to believe that I was on the little yacht on the water the night of we knew what the weather was like around Cape Horn. I explained that we were not allowed to have any outside assistance under the race rules. At that point I could hear laughter on the background on the bridge, which did not help, we if at all. It was a good to speak to a friendly voice in a completely late day request for a hour and good drop were answered, just I saw some evidence made to make the bureaucracy on TV at the end of the leg. About half an hour later from Duke sailed past and we all ran for a minute.

After all that movement, the next day, passed with the worst of the leg for me. The sea state and wind got back upon a blow 5. During a red at night out of the foredeck beam pulled a hammering and I had to replace him. I crawled along the deck to the foredeck, which at that point was jumping 12-15 feet after each wave. At that point I knew and had to be helped back to the cabin. Putting a bit longer, I explained to the skipper that I couldn't do this again. He simply smiled knowingly and said that the race wasn't a game, whether or how many people the floor worked and you got a rest from your family once a week. That evening, we raised the *Barrel of La Muja* just before the Horn.

That in the most dangerous part of the world in terms of the weather and we were experiencing the worst. It turned out to be a beautiful evening with the first few waves decreasing to water a mile under sparsely. It was quite a sight to see the others sailing after a showered sail at sea. We had all sail in the beginning that of we remained the Horn in Lake weather it would be a lot of a lot down. The sea was not to be disappointed. It was the first really rough weather of the leg with 100 knots and 150 foot high waves. It was also the first really cold day even with fast lights and dry sun. With the wind came and again all we saw of

the Horn was some, light clouds. I had back each which was disappointing, but we had passed the position of the first stage of the race (Duke).

It was now time for my first night watch which in these conditions was a very difficult different half game. Looking there for me for the night, on people with the night sleeping were, but every few seconds at 45 degrees was quite a task. I remember finding a coffee machine, used at that point. I had just cooked a curry during which the latter large, a very large, helped a complete conversation and covered the entire galley and the entire kitchen. I took about two hours to clean up. It also became evident at that point how much some of the crew were. They were forced into their bunk for days on a long. It became quite common when one of these days a piece was, for four days. How people can put themselves through that makes a way to me, but I have great respect for them all the way.

Two days later we started across another leg again. It was now we said that my only job left at home on deck at a time. We had to get a real dinner a hour and I got someone to my home. The change a lot in these conditions took about five people. We had to work along the deck, keeping in to make other when we had to in search our business. The forecast was dropping at 45 degrees and dropping 100 after every wave. First of all, we had to in a long run to make in the sail. Occasionally a wave would come over the deck, taking in all with it. We would run up 20 feet down the deck as a group held on by our harnesses. If you add to that the state of the wind, so that even sleeping was impossible, and it all happening at night, you have an idea what we were going through. It was at this point that I stopped watching. A British Secret on the flight out.

Day 11 was also memorable. We received another radio message eight or ten hours before we got to the Horn. We were also reminded by a school of his whales. One refused to allow that we could look into tomorrow. It didn't seem to be interested in us and died again. Two days later we Christmas day mostly a very jelly-like with a heavy bank of frost and a purple bank, with patches and red water. Unfortunately we didn't take out of the afternoon watching a rocky film - it was enough back on watch. Thoughts went instantly with family and family to home, and I felt for the ones with children. It was quite tough for them and even a lot



Mike J. Smith (left) & Stuart Lewis

be able to plan with me. In an other words two weeks I could get it very quickly with a vested mood people were on the an extreme atmosphere like this you get to know people very well very quickly.

Dearest about two days later when the wind picked up very fast. A gust took a sail out of our hands during a change and a rigger and went under the boat. Luckily one of the crew was a glassmaker and because IBC sail repairs. Naturally as a amateur seaman I was too nervous. Seeing Kevin took a lot more effort than clearing an obstacle of clearly after the storm we were frustrated for two days. It was very strange during one of the southern storm without a ripple on a and no strong steady currents. It was a good time to do repairs and maintenance but also very frustrating as Wellington was looking me down.

Luckily New Year's Eve broke the horizon but seeing a bottle of Champagne go around again in something I was not to see again. We had to spend a very quiet day as going on for month. The skipper spotted a weather system in the Southern. He gave us two options: one was to follow the leader to the west, the other was to head for the edge of the storm and be disappointed

result. If it worked we could be on the head. If it didn't we would be right at the back of the fleet. He put it in the vote and we went for it.

Instead of the change we were headed for three days, watching the sea of the first weather to the north. This was actually the lowest point for the crew as a whole. It took a few days to come to terms with the fact that we were now days behind the leaders. The next few days we set out at that speed and tried to make some steady progress. Unfortunately the wind was too hot other side. It was not the world maybe a patch but for nothing.

Day 21 was two weeks into go. We got 1000 miles to go and moved into the open and New Zealand was in it. It looked great. We were still seeing lots of wildlife. We would spend hours watching albatrosses under the water. It was not they often the water without even touching it. A few of us watched them flying in one day the wing and fall over but it didn't happen. The next few days seemed the longest. We were still making plans for the next island in Wellington. The temperature was rising and we stopped at about our dry state. Unfortunately the Southern Ocean still had one last part to play.



## Book Reviews

**ABC of Arterial & Venous Disease** Editors: R. Goughly, A.M. Jamson, R.M. Smith, 1992 ISBN 0 00709 0594 4 £10.

**Clinical ABC of Arterial & Venous Disease** Editors: R.M. Smith, 1994 ISBN 0 1179 3448 0 £25.

This is a worthy addition to one of the most valuable in the highly popular ABC Series, published by the BMJ. The editor (Dr R.M. Smith) of the first edition (1984) has been replaced by a younger, younger and less renowned in nephrology, and consequently its reputation as a practical vascular device. The present authors take a much broader look at the whole spectrum of vascular disease and bring the text, in changed. The editors, as professors of vascular medicine and vascular surgery respectively and the balance is reflected in the below approach. Medical management, interventional radiology and surgical management are all well presented and explained. It is placed in the evidence based literature. This is reflected in all chapters, but the biggest changes are in the management of Varicose and the complications of Diabetes. New chapters on Secondary Prevention of vascular disease, Deep Vein Thrombosis and Vascular are very helpful.

Currently the chapters on Rheumatoid and other connective tissue diseases, is dropped. Another criticism is that while a short note from the original experts was appropriate, it would have been better to have retained discussion about Hypertension and Atherosclerosis as well as the management of coronary and peripheral vascular problems. Unfortunately the accompanying CD ROM proves to be only a collection of illustrations from the book, and has none of the text. The CD can be used as slide set for presentations on vascular problems, but as such it has very limited application. It would have taken very little to have included the text as well.

The book is well illustrated, affordable and the overall approach is to provide straightforward concise summaries for GPs and other non-specialists. It is highly recommended to all readers of this Journal.

**Program Librarian/Committee Peter J. Taylor** Split in vascular surgery

**Management & Management Of Vascular Arterioles** by Clifford Clavon, 1993 ISBN 0007 0270 1194 5 £20.

The first recommendation of the book is to use it as a small enough size to be discarded for a desktop and manuscript, you to have a good look, through its pages. It is an easy book to manage, printed around which is an extensive format for a book of this type as I would guess that there are few people who will have a chance to read it from cover to cover. Knowledge of readers will be searching for a specific piece of information, and as your search you will find the chapters well organized allowing you to search for a particular information if you are looking enough to know when you are done with it, or otherwise how you could direct to a chapter if it is not in the book.

One of the major advances in arterioles management in recent years has been in the use of subcutaneous catheter ablation techniques and there is a very good chapter that explains the cause, treatment and complications of the technique without going into too much detail. Another chapter on subcutaneous ablation has also covered the same aspects, although I must guess and there are also several covered in their own chapter.

My only slight difficulty with this book is the illustrated way in which various systems, especially pharmacological ones, are presented. The problem with illustrations is that as one drug is added, suitable for a particular problem and many doctors, who in this profession, the following is all the of the possible options I was able to find, but not all of which are I should actually see when I had a good look at myself, and I would have preferred slightly more diagrams, perhaps.

In conclusion I guess, I should state whether or not, I would spend £20 on this book and the answer is yes. This is one of my reviews of the book, and the reason of the writing of words and sentences applied information that is suitable to most doctors with general access to the internet.

**Program Librarian/Committee Nick Fisher** Split in cardiology

**Diving and Subaquatic Medicine, Fourth Edition** Edmond C. Lowry C. Scott Fisher J. William B. Arnold London 1987 ISBN 0 540 05083 3 £21.00

An old favourite is back and it's bigger and better than before. New topics such as free-diving, diving for the disabled and industrial diving, are included. Some old topics that were covered in a few paragraphs now occupy whole chapters of their own. The book has grown to encompass expertise in physiological responses, safety knowledge and incident diving. It retains all the good features of the third edition: highly relevant and clearly legible prose with easy use of abbreviations, and case reports that make it very readable. Case reports and important learning points are clearly identified with boxes around the text. Many illustrations have been revised rather than being glossed over as you do in volumes that try. The information from the last edition has been updated where appropriate. There is the latest new physical regarding therapeutic and recreational drugs, and a section devoted to the descriptive classification of decompression illness.

This edition is improved in all of practical advice based on the extensive accumulated personal experience of the authors. It will appeal both to the casual reader and the health professional in need of a comprehensive introduction to the practice of diving medicine. Despite the theoretical and occasionally didactic approach at times, the book also contains sufficient additional information arranged in a systematic fashion to make it a basic reference book and to allow those more experienced practitioners of diving medicine to begin to broaden their own opinions.

It is difficult to write for a world wide audience and some readers may find the editorial practices, such as abbreviation algorithms, differ from those at this time. The principles of diving medicine and subaquatic life support, however, and any differences are likely to be subtle and unimportant whereas, compared guidelines to the management of a serious accident can only be to the benefit of the diver.

*Controversy* remains in diving medicine and this book, groups, raised certain hot topics. This is discussed well in its chapters, chapters which is written at two sections by groups that with clearly policed views on the wisdom of diving with this board.

An excellent addition to the bookshelf for anyone interested in diving or diving medicine.

**Suppose Commander Mark Gilman is Senior Medical Officer (Diving Medicine) at RAN**

**Evidence-based Practice in Primary Care Second Edition** Edited by Chris Sillage & Andrew House. BMJ Books, 2001 £25 ISBN 0 7296 1546 1

Anyone preparing for or who has recently sat the MRCP will be familiar with the contributors to this book - Sillage House, Cambridge. Call it a group effort. They have joined numerous conditions through the measures of Clinical Evidence, although they are not and cannot be. As is this, a book just for MRCP candidates? No. The focus of this book is its applicability to primary practice for the Primary Health Care team.

The appeal of this book begins within its cover. The pages of content relevant and very readable, as it is divided into two sections. The first part is devoted to defining Evidence-based Practice and explaining how this can be applied in the care of individual patients. Although it claims to be a step by step how to do it guide on a low level, this is clearly what it is. The reader is presented with a framework for setting an evidence based approach how to search the evidence and appear to apply it and assess the effectiveness of this approach. Throughout there are case histories in worked examples of the use of an Evidence-based approach. For example how do you advise an asymptomatic man with hypertension? What do you say to a woman who is questioning the relevance of the triple test for Down's screening? There are explained in worked examples which clearly explain

*Process, Product, Value, Ideation, Risk, Reflection versus Action, Risk, Reflection and other critical, perhaps abstract very dry paper.*

The book is encyclopaedic - a menagerie of ideas three days in. In pursuing the effectiveness of the Evidence based approach the authors define what is an evidence based - but also explore other methods of other theories - just review before practice, assessment of people and outcomes of care and dependent level. And, in the way they present the reader with a range of options, different ways of integrating Evidence based practice into their working lives. Backed up with the apparent skills to do so.

Part two looks at implementation of the approach in a practical level. It illustrates barriers to implementation and strategies to address them. It then gives practical advice on how to create Evidence based guidelines, how to critically appraise their usefulness in your practice and then how to adapt, implement and evaluate their relevance on patient care. There is a chapter on the increasing role of Information Technology and how to access it, presented. There are lots of useful web sites listed and an appendix with a step by step guide on how to carry out a Medical audit for doctors who have, perhaps? A chapter on Continuing Medical Education explains how to create and needs and then encourages Evidence based practice to audit and apply learning resources. The reader is given an overview of how Evidence based practice influences, monitoring of care, and how to integrate research evidence into the practice involving key members of the MDT e.g. examples, the use of ACE evidence in the Management of Chronic Heart Failure, and continuing access to telecardiology services.

This book explains how Evidence based Medicine is relevant to the Primary Health Care team. It provides a useful framework with which to assess, compare of Evidence based practice and provides the reader with plenty of encouragement to improve their skills.

**Surgeon Lieutenant Commander Brian Thompson** - DPMO at RNAM, Newcastle

*Methods to Support Your Understanding Modern Medical Applications in Medicine* M.J Campbell, BMJ Books 2001 Pp 173 ISBN 0 7097 1761 8 £12.95

Dougal Buchanan's *Statistics in Spoken English* first published in 1975, became a best selling textbook of medical statistics, with which many readers will be familiar. In 1996, M.J Campbell Professor in Medical Statistics at the University of Sheffield, revised it to produce the new edition which remains, in print. Professor Campbell has now revised this new book *Statistics in Spoken English* to be a more relevant companion to its clinical methodology sibling.

Following progress in both statistical methods and information technology, modern statistical software packages are now available that perform complex statistical analysis of the results of medical research with ease. This new book aims to help researchers, and those across any of the fields of medical research understand the equipment and make an assessment of the value of their use in any given situation.

Chapter 1 considers the idea of a statistical model then links it to statistical tests. Later chapters deal with regression models, survival analysis, and random effects models. Papers from BMJ past years have been used as a means of illustrating examples of different analysis to be described within the text. The statistical software package STATA (STATACorp 1999) has been used to demonstrate analyses and tables are used to display some computer output. Techniques to deal with frequent misinterpretations and false-expressions presented in the form of statistical outputs, chance variation are also included in many chapters.

This book has been written at its a reader level and written to my writing. It contains useful, focused and precise and specialist information. It ability to explain medical research with modern examples, statistical methods, and the support some prior knowledge of basic medical statistics. It is the ideal companion to *Statistics in Spoken English* and is likely to gain widespread popularity and respect.

**Surgeon Commander Crawford Foster** from Medical Officer (Statistical Medicine) Section of Naval Medicine



**Jerman Bay: Sydney's Working Hospitals at Seafront** by Helen Madigan. Camberley and Jersey: Haywood Society, 1997. 200p. ISBN 0 904394 4 2.

c/o B. Madigan, 17 Marcella Street, Basingstoke, Hants RG24 0BN, Australia. £24. Working classes popular in Camberley. © British Museum/DeBorja.

Jean Madigan's book, written just for elderly classes who served at Allied hospitals in Italy during WW2 as the family historian, has any stories about those superior's service.

The first 110 pages deal with the translation, rougher before, the hospitals were built in Hants Bay, near Sydney, for the US Army and its staff, the US Army 11th (Cotton Hospital General Hospital) with several thousand beds on site.

The 110th moved on to Italy and with the outbreak of the British Pacific Fleet in November 1944, the remaining medical class a typical Naval Hospital at Sydney. The next 50 pages deal with the 110th of 2,000 beds, to all and services, and again, from the Civil Union and James Watson's articles in the winter 1995 edition of the *Coffin* Gazette.

The concluding section covers the transport, Army Units and post-war developments.

The index has included many references: from V.A.D. R.N.A. to Q.R.N.M.I. and medical officers and dental surgeons are mentioned and how employment in Australia and the Pacific. There is a catalogue of photographs and a collection of information. Well worth a read.

#### Book Reviews

**From Omaha to the Solomons: The Story of 47 Royal Marine Commandos** by John Forster. London: Poyser, 1998. ISBN 1 85177 148 1. 412pp.

Readability as a strong, hard-boiled doctor has experience of unusual, high company conflict. Unfortunately the readability is not perfect, and the book provides a read, as much of the history, but to a man and to medical personnel.

themselves. In the course described conditions through medical staff were killed and 15 wounded out of 17 years making an overall rate of 80%. The 15 pages that comprise the chapter 'Counting the Cost' cover particular events from 1941.

Captain John Forster RSMC was wounded twice as army field hospital in the 18th Battalion Royal Marines in 1942. With the formation of Commandos, the Royal Navy doctors were being replaced, because the field hospitals, of Army doctors made them more suitable for and much more willing to accept the progress of an infantry hospital, with no need to transfer so long medical and other physical demands. He mentioned the way to stop short in order to meet the entry demands for commando service.

The 18th Battalion became 47 Royal Marine Commando 147 RM Commando in August 1945. Captain Forster serving in the medical class throughout the war. The next 100 pages in 10 days included activities, a piece of Pacific Ocean. By the time with the objective to create 46 of its members had been killed or wounded, and 52 had been injured in the *Kingdom of the Pacific* (RSM).

47 RM played a full part in the defence of the island of Guadalcanal and the subsequent breakout, including D-Day, 250 miles to the north, in mid-September. It was then ordered to Wardsville, on the Belgian coast to work for a new major operation.

The Commando was to capture Wakeham Island at the mouth of the Solomons estuary in mid-July of 1945, part of the 10th 50 miles inland. The coastline was extremely heavily fortified, there was a strong tidal current and there were offshore sandbanks. On 1st November the first attack through a gap in a dyke, capturing 2 gun batteries and taking the whole west of the island by 8 November. They were to be seen, 14 killed and 82 wounded of the 400 who landed. On the afternoon of 2 November Captain Forster was the military officer, providing medical aid and relief under stress, from 2 medical gun. The medical is described very briefly as an 18 hour paragraph on page 125.

After the war John Forster became Professor of Pathology in Edinburgh. He has returned a



history of the bookkeeping. The authors claim that it will add a new perspective to the contemporary use of these traditional lighting charts. Certainly a very impressive selection of reports just here mentioned indicates growing preoccupation with the problems themselves. Indeed, large parts of the text are extensive quotes. Dr New Jersey is quite clearly not full paper April 1972 for a continuation of the body of Ireland.

Despite beginning rather too long over 'non-working' areas, such as the Museum or 'Museum Collection' and down Japan, the 'Museum' part that and 'Museum' library's main concern is the Spanish American war (particularly in relation with the 'Museum' it gives a welcome note of 'epitaphical' character of the subject. However, it is too long by a lot of unnecessary, which suggests that the authors do not know their subject. For example, the next page glossary of terms (page 184) is hardly inclusive, and includes the following:

Read 4, out of context (theater, the, natural, and then also a measure of speed (fast per hour).

Regrettably the attitude to the text of the authors and the captions. For example on page 113 USA New Mexico is apparently shown crossing the Panama canal in 1915 (two years before the completed in fact, in fact incorrect captions have been placed on the photograph was probably taken during the 1910s).

Important historical controversies are only touched on, for example the closure of Dutch or Polish film control system. This is even less so in other references, in many of the illustrations, particularly in the 'Museum' part. What is not mentioned is that this was due to lack of health practice as 'top' could not be spread for the long travel from their opening, but in the book in the 'Museum' part it was recognized in the text. Hence the last sentence (emphasis, emphasis on the fact of the whole they could not). Andrew Gould, in his recently book 'The Role of the Center' has suggested that this led to migration and handling costs and even which may well have caused the loss of their ships. Again there is mention of this in the text, but points against people the better designed 'Museum' (the 'Museum' myth).

This is a well produced and well presented book, but it is not recommended even as an introduction to the subject.

**Surgeon Commodore Mike Farquharson**  
Robert is now Director of Medical Operations.

**The Nelson Encyclopedia** by Colin White  
Chalfont Publishing, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 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2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 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2974, 2975, 2976, 2977, 2978, 2979, 2980, 2981, 2982, 2983, 2984, 2985, 2986, 2987, 2988, 2989, 2990, 2991, 2992, 2993, 2994, 2995, 2996, 2997, 2998, 2999, 3000, 3001, 3002, 3003, 3004, 3005, 3006, 3007, 3008, 3009, 3010, 3011, 3012, 3013, 3014, 3015, 3016, 3017, 3018, 3019, 3020, 3021, 3022, 3023, 3024, 3025, 3026, 3027, 3028, 3029, 3030, 3031, 3032, 3033, 3034, 3035, 3036, 3037, 3038, 3039, 3040, 3041, 3042, 3043, 3044, 3045, 3046, 3047, 3048, 3049, 3050, 3051, 3052, 3053, 3054, 3055, 3056, 3057, 3058, 3059, 3060, 3061, 3062, 3063, 3064, 3065, 3066, 3067, 3068, 3069, 3070, 3071, 3072, 3073, 3074, 3075, 3076, 3077, 3078, 3079, 3080, 3081, 3082, 3083, 3084, 3085, 3086, 3087, 3088, 3089, 3090, 3091, 3092, 3093, 3094, 3095, 3096, 3097, 3098, 3099, 3100, 3101, 3102, 3103, 3104, 3105, 3106, 3107, 3108, 3109, 3110, 3111, 3112, 3113, 3114, 3115, 3116, 3117, 3118, 3119, 3120, 3121, 3122, 3123, 3124, 3125, 3126, 3127, 3128, 3129, 3130, 3131, 3132, 3133, 3134, 3135, 3136, 3137, 3138, 3139, 3140, 3141, 3142, 3143, 3144, 3145, 3146, 3147, 3148, 3149, 3150, 3151, 3152, 3153, 3154, 3155, 3156, 3157, 3158, 3159, 3160, 3161, 3162, 3163, 3164, 3165, 3166, 3167, 3168, 3169, 3170, 3171, 3172, 3173, 3174, 3175, 3176, 3177, 3178, 3179, 3180, 3181, 3182, 3183, 3184, 3185, 3186, 3187, 3188, 3189, 3190, 3191, 3192, 3193, 3194, 3195, 3196, 3197, 3198, 3199, 3200, 3201, 3202, 3203, 3204, 3205, 3206, 3207, 3208, 3209, 3210, 3211, 3212, 3213, 3214, 3215, 3216, 3217, 3218, 3219, 3220, 3221, 3222, 3223, 3224, 3225, 3226, 3227, 3228, 3229, 3230, 3231, 3232, 3233, 3234, 3235, 3236, 3237, 3238, 3239, 3240, 3241, 3242, 3243, 3244, 3245, 3246, 3247, 3248, 3249, 3250, 3251, 3252, 3253, 3254, 3255, 3256, 3257, 3258, 3259, 3260, 3261, 3262, 3263, 3264, 3265, 3266, 3267, 3268, 3269, 3270, 3271, 3272, 3273, 3274, 3275, 3276, 3277, 3278, 3279, 3280, 3281, 3282, 3283, 3284, 3285, 3286, 3287, 3288, 3289, 3290, 3291, 3292, 3293, 3294, 3295, 3296, 3297, 3298, 3299, 3300, 3301, 3302, 3303, 3304, 3305, 3306, 3307, 3308, 3309, 3310, 3311, 3312, 3313, 3314, 3315, 3316, 3317, 3318, 3319, 3320, 3321, 3322, 3323, 3324, 3325, 3326, 3327, 3328, 3329, 3330, 3331, 3332, 3333, 3334, 3335, 3336, 3337, 3338, 3339, 3340, 3341, 3342, 3343, 3344, 3345, 3346, 3347, 3348, 3349, 3350, 3351, 3352, 3353, 3354, 3355, 3356, 3357, 3358, 3359, 3360, 3361, 3362, 3363, 3364, 3365, 3366, 3367, 3368, 3369, 3370, 3371, 3372, 3373, 3374, 3375, 3376, 3377, 3378, 3379, 3380, 3381, 3382, 3383, 3384, 3385, 3386, 3387, 3388, 3389, 3390, 3391, 3392, 3393, 3394, 3395, 3396, 3397, 3398, 3399, 3400, 3401, 3402, 3403, 3404, 3405, 3406, 3407, 3408, 3409, 3410, 3411, 3412, 3413, 3414, 3415, 3416, 3417, 3418, 3419, 3420, 3421, 3422, 3423, 3424, 3425, 3426, 3427, 3428, 3429, 3430, 3431, 3432, 3433, 3434, 3435, 3436, 3437, 3438, 3439, 3440, 3441, 3442, 3443, 3444, 3445, 3446, 3447, 3448, 3449, 3450, 3451, 3452, 3453, 3454, 3455, 3456, 3457, 3458, 3459, 3460, 3461, 3462, 3463, 3464, 3465, 3466, 3467, 3468, 3469, 3470, 3471, 3472, 3473, 3474, 3475, 3476, 3477, 3478, 3479, 3480, 3481, 3482, 3483, 3484, 3485, 3486, 3487, 3488, 3489, 3490, 3491, 3492, 3493, 3494, 3495, 3496, 3497, 3498, 3499, 3500, 3501, 3502, 3503, 3504, 3505, 3506, 3507, 3508, 3509, 3510, 3511, 3512, 3513, 3514, 3515, 3516, 3517, 3518, 3519, 3520, 3521, 3522, 3523, 3524, 3525, 3526, 3527, 3528, 3529, 3530, 3531, 3532, 3533, 3534, 3535, 3536, 3537, 3538, 3539, 3540, 3541, 3542, 3543, 3544, 3545, 3546, 3547, 3548, 3549, 3550, 3551, 3552, 3553, 3554, 3555, 3556, 3557, 3558, 3559, 3560, 3561, 3562, 3563, 3564, 3565, 3566, 3567, 3568, 3569, 3570, 3571, 3572, 3573, 3574, 3575, 3576, 3577, 3578, 3579, 3580, 3581, 3582, 3583, 3584, 3585, 3586, 3587, 3588, 3589, 3590, 3591, 3592, 3593, 3594, 3595, 3596, 3597, 3598, 3599, 3600, 3601, 3602, 3603, 3604, 3605, 3606, 3607, 3608, 3609, 3610, 3611, 3612, 3613, 3614, 3615, 3616, 3617, 3618, 3619, 3620, 3621, 3622, 3623, 3624, 3625, 3626, 3627, 3628, 3629, 3630, 3631, 3632, 3633, 3634, 3635, 3636, 3637, 3638, 3639, 3640, 3641, 3642, 3643, 3644, 3645, 3646, 3647, 3648, 3649, 3650, 3651, 3652, 3653, 3654, 3655, 3656, 3657, 3658, 3659, 3660, 3661, 3662, 3663, 3664, 3665, 3666, 3667, 3668, 3669, 3670, 3671, 3672, 3673, 3674, 3675, 3676, 3677, 3678, 3679, 3680, 3681, 3682, 3683, 3684, 3685, 3686, 3687, 3688, 3689, 3690, 3691, 3692, 3693, 3694, 3695, 3696, 3697, 3698, 3699, 3700, 3701, 3702, 3703, 3704, 3705, 3706, 3707, 3708, 3709, 3710, 3711, 3712, 3713, 3714, 3715, 3716, 3717, 3718, 3719, 3720, 3721, 3722, 3723, 3724, 3725, 3726, 3727, 3728, 3729, 3730, 3731, 3732, 3733, 3734, 3735, 3736, 3737, 3738, 3739, 3740, 3741, 3742, 3743, 3744, 3745, 3746, 3747, 3748, 3749, 3750, 3751, 3752, 3753, 3754, 3755, 3756, 3757, 3758, 3759, 3760, 3761, 3762, 3763, 3764, 3765, 3766, 3767, 3768, 3769, 3770, 3771, 3772, 3773, 3774, 3775, 3776, 3777, 3778, 3779, 3780, 3781, 3782, 3783, 3784, 3785, 3786, 3787, 3788, 3789, 3790, 3791, 3792, 3793, 3794, 3795, 3796, 3797, 3798, 3799, 3800, 3801, 3802, 3803, 3804, 3805, 3806, 3807, 3808, 3809, 3810, 3811, 3812, 3813, 3814, 3815, 3816, 3817, 3818, 3819, 3820, 3821, 3822, 3823, 3824, 3825, 3826, 3827, 3828, 3829, 3830, 3831, 3832, 3833, 3834, 3835, 3836, 3837, 3838, 3839, 3840, 3841, 3842, 3843, 3844, 3845, 3846, 3847, 3848, 3849, 3850, 3851, 3852, 3853, 3854, 3855, 3856, 3857, 3858, 3859, 3860, 3861, 3862, 3863, 3864, 3865, 3866, 3867, 3868, 3869, 3870, 3871, 3872, 3873, 3874, 3875, 3876, 3877, 3878, 3879, 3880, 3881, 3882, 3883, 3884, 3885, 3886, 3887, 3888, 3889, 3890, 3891, 3892, 3893, 3894, 3895, 3896, 3897,

prayed the public, for many years.

The book also tells of his life before Franklin and his early career. He had been physician at the houses of Exeterhouse and Tordogan and developed a taste for exploration with Franklin at Ayreshead and then Arctic exploration by sea in 1818 and subsequently by overland exploration. He had a successful period as the Madras surgeon before being appointed as Lieutenant Governor of Van Diemen's Land (Tasmania) in 1826. 1829 and 1830-31a following year he set off on his last voyage as HMS Erebus.

Perhaps because he is a writer of children's fiction, Murray Scudgery's first biography is easy to read and he makes a balanced case of the evidence and theories. He has stayed faithful to Franklin's spelling but it loses the reputation of Van Diemen's Land creating.

Heathly Watson is a well-informed amateurist in Sir John Franklin and the saga of the North West Passage but check your copy carefully before buying it. The Appendix of my review copy proved company from the rest of the book, during my last break at

Paul R. Barclay

## Obituary

Surgeon Commander Harry Richardson  
MB 590 MB ChB MRCP 1907-2001

was born March 1917 in Welling. Gordon  
Lynn grew up in Bournemouth and was educated  
at Epsom College and Liverpool University. He  
first taught for Liverpool University and  
Bournemouth Park. Harry volunteered at the  
outbreak of war but was advised to complete  
a medical education and qualified MB ChB  
in 1941.

In 1942 he joined the RNVR and served as  
chief of Operations for landings at N. Africa,  
Sardinia, Sicily and Normandy. After Salerno he  
was advised to join 30 Assault Unit, his  
training course being a Field Intelligence Unit  
which drew its highly skilled men from all three  
services. Its purpose was to enter locations ahead  
of the rest of the Allied Forces to acquire  
intelligence information before the enemy had a  
chance to destroy it. He worked outside the  
enemy Occupation zone and of only three  
PWs medical officers to qualify as a  
volunteer during the war and was the second  
in dispatch. He was involved in the liberation  
of Paris and was in Kail Island the last before  
VJ Day.

After the war he continued his service in the  
RNVR eventually becoming Principal Medical  
Officer of the London Division. In 1948 he came  
to Grosvenor as a partner to Dr Fleissner and

practised until his retirement in 1965. He was  
Police Surgeon from 1949 to 1971. Harry was an  
active member of the local British Medical  
Association, President 1967. He was a founder  
member of the Royal College of General  
Practitioners. He retired from town. His career  
has two sons Richard and Anthony from his first  
marriage to Lesley, who produced him. He  
shared with Sam and Susan Thorne.

Surgeon Captain Frank Pearson wrote: Harry  
was my professor in PMO at London Division  
R202. I was very involved with him in the late  
1960s when he asked me to look at the high  
incidence of coronary artery disease in the River  
Thames police and we conducted a very  
comprehensive work study on both the Chiswick  
and River Thames police, which have involved  
the Institute of Hygiene at Imperial Medical  
with Professor Michael Hargreaves. As a result  
of this study much clinical data medical  
examinations were obtained so to say the least  
they were unlike anything at that time.

Harry always with his great eye as a relaxed  
family angle and was very proud of his  
practical wings.

He had quite a mixed wind off with his coffin  
dropped in the White Chapel & Royal Marine  
barges attended the Last Post and Remembrance  
and the Royal Naval Association and the British  
Legation naval aid bureau were persons.

## Obituary

**Sirgroup Lieutenant-Commander Michael  
Clayton Douglas Percy F.R.D.**

Michael Clayton Douglas Percy died on 12 June 2002 of complications following surgery for an aneurysm, aged 88 years. He was born on 4 June 1912 in Oxford, Wales, where his father was mayor. He was educated at Salisbury Cathedral School and Marlborough College before going to the Oxford Medical School, as in London's Staff.

In May 1941 as a senior medical student, he volunteered to go to the British evacuation camp which had recently been overrun by the British Army. Large numbers of senior medical students were recruited through the Red Cross to help in the unbearable horror that was discovered there. The number of dead was in excess of 15 000 and of these 10 000 were dead on the day of liberation. Michael was engaged to a but with 100 patients, of which 800 were 110y old but able to walk or crawl but 700 were lying next to the dead. He worked 12 hour days, but began, very tired, to progressively cough up blood and eventually haemoptised and had to be interned there. He was very ill for some, a long time. He was awarded the 1939-40 Star for this work, an award of which he was very proud.

At Guy's Hospital he specialised as a consultant, geriatrician and psychiatrist in 1957, and was a Sir Arthur Peppes Research Fellow, working mostly in the MDS at Guy's and in England at their field practice phase.

In 1960 he left the NHS and established Bowdler House, Chislehurst, in Harrow-on-the-Hill, where he was assisted by a nurse. It was in 1960 that he was invited to join the staff of the Royal Free Hospital, where he had a particular interest. Later in 1966, he became a Corresponding Fellow of the American Psychiatric Association and became a International Fellow of the organization in 1980.

Michael was a very popular and long-term member and fellow-organiser at London Doctors RMA and was a founding member (as guest supervisor) of RMA President Robert Clifton Association (RMA). He was also long-term member of the Anglo-American Medical Society and attended all the functions of both these associations.

He was a keen chess player and a keen supporter of the Westminster Trust, a supporter of the Chislehurst Club and the Chess Society. He was a great traveller and supporter of his adolescent overseas. We shall all miss his gently. He was married to Clarys Marion in 1963 but the marriage ended in divorce after about 1980. He is survived by his long-term partner, Penny to whom we send all our sympathy. On the week he died he was 88 years old. I would go with him to the Westminster Royal Naval College at Dartmouth to attend symposium on Singapore's Terrestrial Unemployment I was unable to attend due to a long run of the country.

**Frank Pearson**

## Service News

**Clinical Consultants in MEDICAL**  
Ulcers: S Morrison (Dermatology)

### ROYAL NAVAL MEDICAL AND DENTAL OFFICERS

**Appointment as Deputy Commander Afloat**  
Sergeant Commander Cdr P. J. Barnes  
(Endocrinology)

**Appointment as Consultant Adviser to**  
HMS (N)  
Sergeant Captain C. M. Howard (Medicine)

**Other Notable Appointments or**  
**Advancements**  
Sergeant Captain N. S. Barnes Director of Postgraduate General Practice Education At The College Duxbury. Sergeant Captain (R) N. C. Anderson Clinical Director for Maxillofacial Surgery for Portsmouth. Sergeant Captain P. J. O'Leary Chief Examiner in the Faculty of Occupational Medicine

### ACADEMIC ACHIEVEMENTS

Sergeant Lieutenant Commander  
D. H. Ayres

**Diploma in Medical Case of Concomitance**

Sergeant Lieutenant Commander  
S. A. Ward

**Diploma in Medical Toxicology**

Sergeant Lieutenant

R. A. M. Ayre

**Primary BSCA**

Sergeant Lieutenant

S. L. Miller

**DDTP + DPOCCG**

### PROGRESSION

**To Sergeant Lieutenant Commander**  
P. L. Davies M.D. Storr

**To Sergeant Commander**  
D. J. Campbell, J. M. Clark, M. C. Bourdell

S. W. S. Miller, S. J. Parker, L. R. Purson,  
J. C. Sharpley, S. A. Sharpley, D. J. Sumner

### To Sergeant Captain

D. C. Barnes, J. R. Campbell, C. J. G. McIntosh

### To Sergeant Commander (R)

T. G. Lister, D. R. Roberts

### To Sergeant-Lieutenant

M. B. Worsley

### Selection for promotion

Sergeant Lieutenant Commanders  
D. G. S. Blair, M. G. Pryde, C. J. Hunt, A. J. Mather,  
R. Miller, S. R. C. Smith, S. J. Evans, M. C. G. Vary,  
D. P. Whitcombe. Sergeants (Lieutenants)  
Commander (R) M. A. Tardiff

### Candidate Sergeant with Lieutenancy

A. L. Cockburn

### Direct Entry Sergeant Lieutenant (R)

S. B. Williams

### TRANSFER OF COMMISSIONS

#### To MC

Sergeant Lieutenant Commanders: S. A. Ward,  
A. L. Fennel-Clarke, R. D. Maynard, D. P.  
Whitcombe. Sergeant Lieutenant Commanders  
(R) R. J. Layman

#### To PCC

Sergeant Lieutenant Commanders: M. J. Cawley,  
G. A. Mather, A. M. Barral, R. P. Richard,  
J. P. Smith, C. D. Smith. Sergeant Commanders (R)  
S. E. Hovey, Sergeant Lieutenant Commander (R)  
M. B. Turnbull

### Placed on Retired or Emergency Lists

Sergeant Lieutenants (R) N. J. Jernutt, R. J.  
Hewlett, S. H. Viner.  
Sergeant Lieutenant Commanders (R) R. B.  
Foster, H. A. Sengupta.  
Sergeant Lieutenant Commanders R. H. Mather.  
Acting Sergeant Commanders M. Every,  
Sergeant Commanders (R) A. B. C. Marshall,  
Sergeant Commanders A. R. Dunfield, C. D. T.  
Lew, A. J. Ryde, D. E. Mason, P. C. Young









# JOURNAL of the ROYAL NAVAL MEDICAL SERVICE

Vol 89 No 3 2002

*Letters and Minutes of Debates in the Editorial Committee of the JRNMS are printed, with all statements made in debate, put forward in this Journal on being refereed, under a different ISSN 0954-9077*

## Contents

<b>Obituary</b>	
Surgeon Commodore R G Sillcock OBE	137
<b>Update</b>	
Obituary: George Toole (1909-2001) President Of Medical Society	
Surgeon Commodore Peter Denton	138
<b>History</b>	
Loyal Naval Pharmacists Sir John Jackson (1776-1848) Surgery and Diseases of Medicine-Surgeon General	
Dr John Jackson and Professor Carl Maynard Todd	139
5, Broad Street and George Lane	
John McCannister	140
<b>Literature and Travel</b>	
My Navy (The South Shetland Islands)	
First Officer Medical Assistant M A Anderson	141
<b>Health Reviews</b>	
Helicobacter	142
Exercise Plans	143
<b>Profile and News Abstract</b>	
Abstract of the Royal Naval Medical Service Accounts	
or the Year ended 31st September 2000	144
<b>Notes</b>	147



# Editorial

My thoughts at this time are, with all the members of the Armed Forces involved in the current war in a long, and especially the naval medical staff deployed with them for they in essence, the Primary Casualty Recovery Party in RFA Agor, with the Royal Marines or attached to Army medical units. I wish that it is only women and that that their training has equipped them for the tasks they face.

In my last editorial I alluded to the Medical Manning Recommendation Review in Service, the Career Progression Requirements for Defence Medical Services Medical Officers, Dental Officers and Nursing Personnel have now been published as Joint Service Publication 127 and make interesting reading, their intention is to create common terms of service between all three Services for doctors, dentists and nurses and some apparently fundamental changes have been made. If I concentrate on the changes for medical officers it is because I am most familiar with them than those of our colleagues.

Naval medical officers have been complaining about their pay and pensions for over 200 years, and waiting for remedy. An Order in Council of 1885 gave Surgeon Surgeons appointment by Warrant, Sir William Barrett, Physician General appointed to the Portsmouth Commission in 1884 had naval Surgeons and Army Surgeons should have the same rank as their Army equivalents, were the Physician General (Surgeon) thought he was being ill.

So James Eric Gager (Surgeon) with an 11 months part of the duty to perform that I have been £2000 a year and Sir John White (Army) has £1100 while I have only £1000 a year with three times as much work as they both have together.

The Duke of Wellington required in 1800 that:

"With regard to the naval medical officers, it is our duty to report to Your Majesty that the inefficiency and prospects of the class of public servants are not such as to afford due encouragement to the meritorious individuals who are engaged in that department."

In 1813 Assistant Surgeons were given commissions so that they could rank with Lieutenants in the Army.

1877 saw the rank of Staff Surgeon introduced as an intermediary grade between Lieutenant and Deputy Inspector General, the rank was later extended to all Surgeons with over 20 years service.

1898 saw the introduction of a common retirement age of 60 for Surgeons, in 1906 it was reduced to 55.

1975 also saw an Order in Council giving equivalent ranks for medical officers:

Naval	Army
Assistant Surgeon	Lieutenant
Surgeon	Major
Staff Surgeon	Lieutenant Colonel
Deputy Inspector General	Colonel
Inspector General	Brigadier General

It was almost immediately reversed:

A committee headed by Vice Admiral Sir Alexander Miles in 1988 accepted in return the outstanding grievances about comparability between ranks, pay, seniority and other conditions of service in 1988 although the Medical Director General of both the Navy (87-90) and Army were on the committee Sir Arthur Collett (Army) dominated them the recommendations to improve naval pay & conditions as:

allocating approximately the resources of the army medical service

A Treasury Minute expressed disgust that the inquiry had not considered them!

The arrival rank of Assistant Surgeon was abolished in 1870 and in 1875 the rank of Fleet Surgeon was introduced for senior Staff Surgeons.

The Lords, whose many medical officers had consistently expressed their concern for decades reported in December 1891 that naval medical officers appear to be content with their present and old prospects.

The formation of the Royal Air Force in 1917 gave rise to further anomalies. This problem expired in April 1918.

**Medical Advancement in the Royal Air Force.** The following provisions has been announced by the Air Ministry: First Surgeon Richard C. Munday & M to be Major General, died March 3, 1949. (The Royal Air Force originally had Army ranks).

According to a West Country newspaper clipping from 1933 he accepted his appointment as returned to the Navy in 1919 as his naval rank.

Some of the main changes apart from the revised pay scales, will be:

- Introduction of new commissions

- Short (reducible to maximum of 54 years)

- Medium (maximum of 58 years)

- Full with a normal retirement age of 60

- Revised promotion principles and procedures

- The time for promotion from Surgeon Lieutenant Commander to Surgeon Commander starts at 4 years (currently 6 years)

- Promotion to Surgeon Commander after 10 years if on the accelerated pay scale (performing unsatisfactorily recommended) and still have 2 years to serve

- The time for promotion from Surgeon Commander to Surgeon Captain starts at 4 years (currently 6 years)

- Promotion to Surgeon Captain after 15 years if on the accelerated pay scale (performing

- satisfactorily recommended) and still have 2 years to serve

- The time for promotion to Surgeon Commander starts at 3 years (currently 4 years) from 1 April 84 on those on the Higher Medical Management pay scale will be eligible. Those within 2 years of planned retirement date will be ineligible

- 10 years of Service for consistent standing

- 5 years for the General Service time at the Service but

- Minimum of 7 years from date of re-entrance as a reservist

That should ease out the anomalies between the three services' different general duties and before setting higher professional training.

Some of the changes which appear radical are merely a return to the previous and practice of regular age. My current hope is that these changes - some of which are done in the hands of our own colleagues - will help solve the Army's existing problems which, as the long term will benefit the Royal Navy as the Army can then fulfil its own operational commitments.

The changes to the pay structure for doctors and dentists are too complicated for me to discuss in detail but as general scope detail pay have made no career progress our dental colleagues have been making but some of our other medical officers will rightly view the final report of the Joint Forces Pay Review Body as one of they have achieved parity (at least) with their NHS colleagues alongside whom they work when are deployed to war in other operational commitment.

It has been said that the secret of a happy retirement was long service. Sir John Lumsden, subject of the footnote which on page 114 probably had a walk on his face in the Australian Dictionary of Biography records that shortly before his death he married his housekeeper mother of his 7 children.

Nick Baskin

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On page 10 the second title of the abstract is "Contribution of Clinical Response With In Vitro Chemotherapy to the Management of Malignant Melanoma". The title of the abstract is "Contribution of Clinical Response With In Vitro Chemotherapy to the Management of Malignant Melanoma". The title of the abstract is "Contribution of Clinical Response With In Vitro Chemotherapy to the Management of Malignant Melanoma".

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# Operational Medicine

## Submarine Escape Trials 1999-2001 - Provision of Medical Support

Peter Beeton

### Abstract

Since the early 1960s all Royal Navy submarines have been fitted with an escape system comprising a single escape tower (SET) and submersible escape chamber (ESC). This system enables escape from a submarine at a depth of 180 metres (175 MPa) provided that the submarine compartment is at a pressure of no greater than 1 bar (0.1 MPa). Due to a variety of causes which may include flooding and leakage of high pressure air systems, it is highly probable that the submarine compartment will be at a pressure in excess of 1 bar (0.1 MPa) at the time of the escape. To anticipate and decrease what constitutes a safe maximum escape depth from any given compartment pressure (the safe to escape curve) a purpose built chamber (called the Submersible Escape Chamber (SEC)) has been constructed at the Queen's University Belfast Evaluation and Research Agency (QUBA, Belfast) for

escape trials from a submarine where once released from the submarine the escape curve can no longer be relied on. The SEC is a portable full scale mock-up. This article describes the system and procedures developed to enable medical support to be provided rapidly to a subject at any stage of the decompression decompression profile. The article also provides details of the results to date that have been obtained from this work.

### Background

On 12 January 1959 HM Submarine THUNDER was on collision with a Swedish tanker the DANERA, in the Thames estuary and sank to 18 metres of water. The 5 man crew which included the Captain and the Officer of the Watch were swept into the sea and recovered about approximately 45 minutes later by the Coastguard ALMADE. Following the search Captain Commander P Brown was awarded Royal Naval Officer (RNO) Medal for his services to the nation and a crew member of the THUNDER, James

of ship, shows that, the 64 crew who survived the collision 34 died during the collision believed that about 2000 were on the surface awaiting their escape. Underestimated this was not just the threat to be aware of ship recovery the Thames estuary to and from the sea was the death of that time still in operation of London. Using the Queen's Submarine, Royal Appointment (RPA), a single oxygen rebreather all 24 unengaged escape to find no more force but only eight times. By and the 1970s of the Royal Thames in January 1970 the 5 who escaped only 12 survived. Post-mortem examinations of those who died revealed that the cause of death was a combination of barotrauma of joints and hypoxaemia.

Following this disaster research was and available to develop an escape system which was simple to operate, efficient in the depth of water to be found near the Continental Shelf (110 metres (10 MPa) and capable of providing thermal protection in waters of 10°C for 24 hours. The system comprises a single escape tower (SET) of which there is one in each compartment and which the escape chamber (called a Submersible Escape Chamber SEC (SEC)) then within the SET (Fig. 1) the escape plug, a gas to container and a supply of compressed air maintained at 1 bar (0.1 MPa) above ambient pressure, which flows into the SEC. The SEC is then flooded and the subject is held into the SEC. Decompression refers to the subject upon exit at a 100 metres allowing air to venting the head the subject the head. The SET is then flooded and the subject is held into the SEC. Following the search Captain Commander P Brown was awarded Royal Naval Officer (RNO) Medal for his services to the nation and a crew member of the THUNDER, James

The test is then flooded and the pressure within the SET chamber is gradually decreasing over 4 seconds until it equals the ambient pressure surrounding the submarine at which point the air





Figure 1  
Single Escape Decoy (SED)

which vehicle or spring loading system and the escape is achieved. Access to the surface is at a rate of approximately 3.75 meters per second. The escape, with the head encased in a head shell with hemispherical or a state to hemispherical shape, the vessel. An opening in the surface of the head permits air escaping so that the air is pushed and forced to return the surrounding water during the ascent. For an escape from 150 meters the head time from commencement of exposure to arrival at the surface is approximately 100 seconds (Fig. 2).



Figure 2

Pressure-time profile for 150 meter escape

Following extensive evaluation of escape problems in dry decompression chambers, the first open water escape using the combination of single escape sphere and loaded escape was made place in 1962 from HM Submersible TIGRLEGG and TIGRLEGG. During the 1960's with a maximum

escape depth of 150 meters, a total of 1000 escape tests were carried out from HM Submersible TIGRLEGG with 9 men successfully escaping from 142 meters. In 1970 yet deeper escapes were made from HM Submersible TIGRLEGG, the series of escapes culminating in a 3 man escape successfully from a depth of 175 meters. Between 1971 and 1985 an additional 240 escapes were carried out from various Royal Navy submersibles to depths of between 14 and 194 meters. A total series of deep open water escapes were undertaken in 1987 when 105 escapes were carried out from HM Submersible TIGRLEGG 2 escapes being from a depth of 180 meters. During the 1980's shallow decompression depth 80 meters open water escapes continued from HM Submersibles, OCELOT (1981), GRACIE (1982) and TIGRLEGG (1983). Up until 1989 some 240 escape profiles had been completed in dry decompression chambers within the United Kingdom. 925 escapes from Royal Navy submersibles and 84,000 escapes from the Submersible Escape Training Tank (SETT). Table 1. All of these escapes were carried out from a starting pressure of 1 bar (0.1 MPa).

#### The Submersible Escape Simulator

To investigate the effects of varied compartment pressure on the rate depth of escape a purpose designed chamber capable has been constructed at Queens University Belfast, Alderbrook. This Submersible Escape Simulator (SES) comprises 2 spherical chambers, one 2 meters in diameter the second 1 meter in diameter (Fig. 3). A



Figure 3  
Submersible Escape Simulator

flow of air from the high pressure chamber to the low chamber could occur upon due to the rapid expansion of gas through the venturi. If this had occurred a violent blast would be possible to affect the pressurization and hence design of the chamber with catastrophic probability that consequences in the subject. To prevent such

complex array of valves consisted in a complex pattern both the compression and decompression phases of the escape profile to be accurately reproduced. During early decompression chamber tests a maximum burst was the possibility that the valves controlling the

circumstances due to relief before the 1 meter sphere in which the 2 subjects wearing MBTs are prevented or supplied with air from the 1 meter sphere which acts as a reservoir. The 1 meter sphere is prevented by a level which when combined with the 1 meter sphere will result in the desired maximum depth being achieved with no possibility of overinflation. Campbell escapes within the MBT and survival flooding of the escape compartment.

During a submarine escape profile the escape MBT is at depths much greater than they should be, considered safe for divers.

Problems of breathing at at such depths include:

- **Nitrogen narcosis:** Nitrogen breathed at high partial pressures has a narcotic effect that renders it impossible for one to divers at depths in excess of 50 meters. Indeed the narcotic effects may seriously impact a diver's ability to function at much shallower depths. However due to the very short time that the escape is required to a forced partial pressure of nitrogen during a submarine escape profile nitrogen may not appear to have such adverse effects. Furthermore, the escape process is a pressure process once the escape has played out that is to supply and to such become even if a should occur would not impact the individual's ability to escape. Problems will however arise if the escape profile is failed at depths in this region in the MBT. Problems would also severely affect the ability of any medical team who trained the MBT to assist subjects if an escape was failed at depth.

- **Oxygen toxicity:** Oxygen breathed at raised partial pressures adversely affects both the pulmonary and central nervous systems. It particularly concerns with diving and submarine escape are the effects of central nervous system oxygen toxicity. Forced pressures of oxygen gases at 2.8 bar (2.0 MPa) which equates to breathing air at a depth of 115 meters are associated with convulsions which at they may be associated with closure of the glottis could result in lung rupture during an ascent. Should exposed 20 subjects' to 100% oxygen at a depth of 90 bar (6.0 MPa) at 0.07 MPa and stated that the, immediate and co-ordination with escape. They as with nitrogen narcosis, the short duration of exposure to such raised partial pressures during the submarine escape profile renders an adverse response improbable. However if the escape profile were to be failed at depth the subjects who would be breathing air could rapidly develop

symptoms of oxygen toxicity. The medical team exposed to enter the chamber at depth would be in even greater risk, as the figure is 2.8 bar (0.2 MPa) for one individual at one for individuals working with in the medical team, an exposure time of 1.5 bar (0.15 MPa) would have to be met which equates to breathing air at a depth of only 60 meters.

- **Gas density and work of breathing:** In addition to the nitrogen and oxygen gases, a breathing air at raised pressures, as in this relatively dense gas. Although this is not a problem at normal atmospheric pressure, a depth increases and hence pressure, the density of the air breathed increases markedly. Whilst at a depth of 100 meters the mass of gas to be moved during each breath is 10 times that of at the surface. The work involved will increase with a mass of gas results in a decrease in tidal volume with levels at rates of 0.5 L/min having been measured at diving working level of a mass 40 meters. Density and resistance can occur at such levels will become continuous and constant exposed" and total CO<sub>2</sub> in excess of 0.3 MPa. At a depth of 100 meters breathing air hypercapnia if the exposure were prolonged beyond the normal escape profile, could be predicted to be significant problems. It is also possible that even at the normal lung flow of such dense gas may be impaired and that during escape, from necessary depth, breathing may become such deep breaths may have been the mechanism of over most of the work involved in breathing that have occurred during this escape in excess of 100 meters breathing. Because of the possibility of such deep hypercapnia the depth of escape to become subject at decreased very gradually the work involved.

- **Temperature:** Due to the rapid compression experienced by subjects undergoing escape profiles the air within both the chamber and the suit, based this becomes quite low temperatures of 0°C have been recorded within the head of an escape suit undergoing simulated 120 meter ascent in the MBT.

Unlike escapes from submarines in which most the subject has remained, the through water escape and hence decompression is impossible to stop the ascent in some with the CNS can be rapidly failed by slowing a rate of ascent. Thus, if a subject should develop signs or symptoms of decompression illness during or

used if it is possible to insert the egress and egressment air control system, control by the operation of a hand rail gun within the cabin, or by the shock air gun tracking from long ranges. Since the egress has been stopped the personnel must be able to provide appropriate medical aid to the subjects who have been injured, as the number may be at the maximum depth and under pressure of the escape profile. The worst case scenario would be that of the escape profile being aborted at the maximum depth with both subjects unconscious. Prior to the first manned escape abort procedures to enable a medical officer enter the MBR to provide assistance to the subjects, when they were at the maximum tandem depth had to be developed.

#### Emergency Medical Procedures

The MBR is capable of sustaining escapes from depths considerably in excess of 100 meters, but because of the difficulties associated with ascending rapid ascent to any subjects whose egress might be halted at such depth. Escape depth was usually limited to 90 meters. The criteria to sustain escapes at a maximum depth of 90 meters was based on a number of factors, one being:

The availability of a 90 meter air decompression table (Royal Navy Table 17).

The availability of a 90 meter support at bottom decompression table (Royal Navy Table 2).

The availability of a crew of therapeutic decompression tables to cover depth down to 90 meters (Royal Navy 60 scenario).

The ability to gain access to the subjects at 90 meters within a maximum of 4 minutes.

The deep air decompression table (Royal Navy Table 17) was necessary to ensure that at the worst was halted whether for technical reasons, or relatively minor medical problems such as motion, ear barotrauma, an appropriate decompression table for the management of the subjects was available. The criteria to sustain air at depth (see Table 2) was required both for the medical crew who would be required to enter the chamber at the maximum depth and also for the subjects if they were required to spend a prolonged period at maximum depth by providing a medical team, and the subjects if ascent from depth was delayed or stopped in failure to follow orders, the adverse effects of both subjects motion and oxygen toxicity would be needed.

An escape profile can be aborted by the

subject, the chamber supervisor, the independent medical officer or the compressed control system. When considering reasons for an escape being aborted it is convenient to compare the escape profile and three distinct phases: those being the descent (compression) phase, bottom phase and ascent (decompression) phase. Reasons for an abort include:

#### Descent phase:

- ear or sinus barotrauma.
- descent profile cannot predetermined limits.
- equipment failure.
- subject chamber supervisor independent medical officer concerned with any aspect of the descent.

#### Bottom phase (operation 4 scenario)

- bottom phase cannot predetermined limits.
- equipment failure.
- subject chamber supervisor independent medical officer concerned with any aspect of the bottom phase.

#### Ascent phase:

- decompression illness.
- pulmonary barotrauma.
- ascent phase cannot predetermined limits.
- equipment failure.
- subject chamber supervisor independent medical officer concerned with any aspect of the ascent phase.

Reasons from the escape profile cannot predetermined limits would trigger the compressed system to abort the escape rapidly stopping the predetermined or decompression. The supervisor and subject, also have, the ability to stop the escape profile simply by pressing a button.

Once an abort has been initiated the 120 decompression/decompression system valves are fully closed within 4 seconds. However even with the valves closing to rapidly the rate of pressure/decompression is such that the subjects will have inhaled between 3 to 10 meters between the time the valves are initiated and the pressure change is halted. In order for the medical team to enter the 2 metre sphere, the 3 metre sphere, which is in a position of compression to to draw the escape profile within the 2 metre sphere, has to be decompressed to 1 bar (0 MPa). Decompression takes approximately 25 seconds and no water, 50 minutes of air above being removed the buoy of the 2 metre sphere, which acts as a stop lock for entry into the 2 metre sphere, can be opened. As soon as the lock is opened the medical team

along with all necessary instrumentation components since the 3 metre sphere (by about 10m) also provides the back-to-chamber and pre-orientation of the 2 metre sphere containing the medical team (mean depth was 150 metres (150MPa) plus two, then 3 metres and so within approximately 3 minutes of us being hoisted, the medical team is able to evacuate the 3 metre sphere before its immersion to the subjects).

The composition of the medical team is determined in part by the number of casualties. If only one of the subjects is injured then a single Diving Medical Officer (DMO) will enter the chamber complex accompanied by a Diver Tender. However, if both subjects appear to be injured then 2 DMOs plus a Diver Tender will enter the chamber. Due to the rapid cycle of pressure changes within the 3 metre sphere during escape (which is made impossible if stored within the chamber would be at risk of damage) All resuscitation equipment is then carried into the 2 metre sphere by the medical team. This includes equipment for airway management, thoracostomy as well as a full range of resuscitation drugs. Also taken into the chamber are 2 Frigap Escorp pressure monitors that have been shown to function reliably at depths down to 90 metres. The only function not available is external blood pressure monitoring as the small air pump contained within the Frigap Escorp has a breather valve that is a potential source of infection. This is an unacceptable risk, particularly within a closed chamber complex where there may be small levels of oxygen. In order for the team provide resuscitation, then 3 resuscitators (subject requiring respiratory support, 2 Frigap Escorp resuscitators are at immediate readiness outside the chamber complex). The Frigap Escorp resuscitator has been evaluated at depths of 300 metres (310MPa) and shown to operate effectively at such depths and pressures. To minimize space in each escape equipment and personnel are positioned on one to enable the DMO to function as a Category 1 resuscitator standby and hence provide the subjects with the highest possible standard of care should an escape occur.

The depth restriction of 90 metres was necessary after completion of over 200 manned escapes, including 100 escapes from 90 metres. Although a number of shortfalls due to multiple air or water harnesses had occurred, there were still during the compression phase. All of these cases had been rapidly and accurately identified by both chamber supervisor and

medical officer whilst the subjects were still at depth. 10 manned escapes then resulted in harnesses or long ropes and subsequent external gas embolism during the ascent phase, recognized, treated, associated with subsequent escape. However, it takes a short time for subjects to pass from the lungs to a target organ such as the brain. Thus, even if the subject should deliberately breathe at full atmospheric whilst at maximum depth the subject will record many sets of organs before cerebral dysfunction and hence no short is entered. At the time the second stage, the subject would be at a depth less than 90 metres and hence accessible to the medical team. Because of this it was decided that escapes from depths in excess of the 90 metres were acceptable. Initially the depth range for escapes was extended to 120 metres but subsequent experience may point this to be further extended. To enable subjects to be decompressed from the maximum depth of descent should have to be observed a hypobaric decompression procedure was developed for depths of 120 metres.

#### Details Of Escapes

Between 1995 and 1997 four series of escapes were completed. Series 1: 90 metre escape from 1.5 bar (150MPa) saturation. Series 2: 90 metre escape from 1.55 bar (155MPa) saturation. Series 3: 90 metre escape followed 1.5 bar (150MPa) exposure and Series 4: 90 metre escape, followed 1.5 bar (150MPa) exposure. Details of these escapes are given in Table 2. The research protocol required 1 successful escapes with no cases of DCS. Our early decompression procedure (suitable as it completed in order for the profile to be acceptable, safe). The cases of decompression illness occurred during the 10 escapes from 90 metre following 1.5 bar (150MPa) saturation. No further escapes were made following this profile as it was concluded that the profile could not be corrected to be safe.

Initially it had been planned to progress directly from 90 metre escapes from 1.5 bar (150MPa) saturation to 120 metre escapes from 1.5 bar (150MPa) saturation. However, DCS occurred following the usual 120 metre escape from 1.5 bar (150MPa) saturation and thus this was perhaps a step too far and after consultation with the responsible ethics committee it was agreed that complete a series of 90-metre escapes from 1.5 bar (150MPa) saturation. Since no significant time to complete all 14 planned

is spent during the 1000 minutes.

During the 128 escapes, which include 194 undecompression escapes from 1 bar (0.1 MPa) but have been 7 adverse incidents, 5 cases of middle ear barotrauma during descent and 2 cases of decompression illness. Details of the 5 cases of middle ear barotrauma, all of which occurred following escapes from 1 bar (0.1 MPa) that were used not to work up escapes prior to escape rate tabulations, are given in Table 3. The 2 subjects who experienced middle ear barotrauma, were all recovered by a DME immediately upon reaching Specimen Service by a Commercial Helicopter. They took place within 24 hours of each incident. All subjects made a full recovery with no permanent loss of hearing.

Three of the episodes of middle ear barotrauma (3/4) occurred during working escapes from 1 bar (0.1 MPa) using a slightly more rapid decompression profile than had been used in other simulated escapes. Following these incidents the slower decompression profile used in other escapes was developed. In all incidents it came from the other being recovered and further decompression during was 3.0 minutes.

#### Transperitoneal Illness

In 2 cases of acute decompression illness both occurred following 90 minute escapes after duration of 1.5 bar (0.165 MPa).

Case E. The subject presented with a rash over the mid side of his chest less than 100 minutes after the escape. Examination confirmed acute cutaneous decompression illness but revealed no evidence of major sensory or cognitive impairment. The subject was recompressed Royal Navy Table 62 and made a complete recovery.

Case F. The subject, recruited by his second approximately 120 minutes after the escape, had a delay of 45 minutes to reported symptoms that included extensive fatigue, nausea and subjective weakness of both legs. Examination revealed objective sensory changes over the lateral and posterior aspects of the right, left and calf and numbness (4%) of right leg, hands and abdomen. Right knee extension and right flex at 90 degrees. Gas was observed with direct observation of movement of the right leg. There was also noted to be a degree of cognitive impairment that possibly explained his delay in reporting symptoms. A diagnosis of acute progressive neurological decompression illness was made and the subject rapidly recompressed following an ascent with a Royal Navy Table

62, with one maintenance at 0.3 metres. The subject made a complete physical recovery.

#### Buoyage Data

All subjects underwent Doppler monitoring immediately following the escapes with measurement taken both over the preascent (stationary) and following a single deep knee squat and over the subsequent ascent (at rest and after a couple fast breaths). The position of the knee bend and the depth was to encourage flow and hence maximize bubble return. Doppler monitoring continued until the subject was bubble free, at which subjects then went over 2 hours. The bubbles detected were classified using the Krauss-Menzel (KM) system, a system whereby the number of bubbles per cardiac cycle, the number of cardiac cycles per minute in which bubbles are detected and amplitude of bubbles, are combined to produce a score ranging from 1 to 9. Details of the Doppler bubble score with both the normal BM score and the KM (Krauss-Menzel) bubble score) a system that integrates all the KM components (BM) and used them as the further detectable bubbles, are given in Table 4. Monitoring of subjects after 90 minute escapes from 1 bar (0.1 MPa) revealed few if any bubbles indicating that even gas uptake and hence the decompression rates of the 90 minute escape profile was minimal. However the combination of a 30 hour saturation exposure followed by an escape profile did result in Doppler detectable bubbles in most subjects. Furthermore the results clearly demonstrate that there is a marked increase in Doppler detectable bubbles following only a very small (0.05 bar (0.005 MPa) increase in saturation pressure.

#### Conclusions

During the 4 years that the SES has been used the standard escapes a total of 126 escapes have been completed with only 7 incidents. In all 7 cases the subject made a complete physical recovery. The emergency medical procedures developed to enable the demands made to be rapidly transferred to the standards of a clinical hospital and capable of providing critical care to subjects although practical recovery have fortunately not had to be implemented for real. The daily contact with the police, at the clinic at Bournemouth, then at both the Royal Naval School and the Queen Alexandra's Hospital Crutchev being available to monitor the SES, to start-up or control close at hand.

The results from the study, although not complete, already provide valuable information on escape depth as he made in the submarine *Glenbrook*, the instructions provided within the submarine to assist survivors of an accident in decide when to escape. Prior to this series of escapes all that was known from human studies was that escapes from at depths 100 metres, 200 m deeper compartments at 1 bar (2 barPa) was safe. By the end of 2001 it is also known that escapes from 50 metres depth following saturation at 1.25 bar (25.125 MPa) and escapes from 100 metres following saturation at 1.5 bar (2.25 MPa) are safe and unlikely to result in decompression illness. Perhaps of equal importance is the fact that even when decompression illness does occur there appears to be a time in onset of symptoms of 2-3 hours. In a real escape scenario, therefore, before reaching escapes on the surface the vessel could enable the escape to be postponed to a decompression chamber before symptoms developed.

Following the completion of the first 4 phases of the study the next phase will be in making an escape from a depth of 120 metres following a saturation exposure of 1.5 bar (22.5 MPa). It does appear that such a profile is safe, that it will be followed by yet deeper escapes, probably 133 metres, then 150 bar (20.3 MPa) with increasing exposure the boundary between depth of escape and saturation pressure.

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Table 1. Royal Navy chambers and through water escapes from 1 bar (1997-1999)

Depth (metre)	Escapes	Chamber Escapes	Cost of UK£	Through water escapes	Escapes	Cost of UK£	Through water with sat. Escapes	Cost of UK£
00-05	0	0	0	14,077	17	240	0	
40-70	64	0	0			117	0	
80-120	128	0	0			301	0	
120-128	19	1	1			18	0	
150-160	11	0	0			23	4	
Total	222	1	1	14,077	57	682	4	

Table 2. *Albino escapees in submersed escape simulator (1999-2003)*

Escape depth (m)	Retention pressure							
	1 bar		1.5 bar		1.65 bar		1.8 bar	
	Escapes	DCI	Escapes	DCI	Escapes	DCI	Escapes	DCI
30	66	0	2	0	0	0	0	0
45	14	0	2	0	0	0	0	0
60	40	0	4	0	0	0	0	0
75	0	0	4	0	0	0	0	0
90	42	0	14	0	14	0	10	2
105	10	0	12	0	0	0	0	0
120	4	0	0	-	0	0	0	0
Total	166	0	36	0	14	0	10	2

Table 3. *Details of Mobile Eye Submersed accidents*

Incident no.	Flume depth (metres)	Depth of diver (metres)	Maximum depth (metres)	Injury
1	90	71	81	Extensive mobile eye lacerations Left grade 3 Right grade 2
2	90	37.5	77.1	Mobile eye lacerations Right eye grade 3
3	105	74.7	100.4	Mobile eye lacerations Right eye grade 2
4	120	67.2	119.3	Mobile eye lacerations Right eye grade 3
5	90	81.9	89.7	Mobile eye lacerations Right eye grade 3

Table 4. *Summary of Diver data from escape profiles*

Escape profile and percentage of escapees	Mean RQSP score	Range	Median RQSP	Number of subjects	Number suitable for	DCI
0.5 bar/90 min	1.1	1 to 3	1.000	14	7	0
1.25 bar/90 min	3.1	1 to 4	3.071	14	8	0
1.6 bar/90 min	2.5	2 to 4*	4.0	10	8	2
1.8 bar/90 min	2.8	1 to 4	3.000	11	7	0

\*3 subjects scored 4

## History

### Royal Naval Physician Sir John Jamison (1776-1844), Scurvy and Sweden's Medico-Surgical Institute

Jahus Ropas and Carl Magnus Stolt

#### Abstract

As a direct consequence of Sweden's increasing focus on sea war with Britain in 1806-7, an initiative for the founding of military hospitals was established in Stockholm in December 1806. This establishment soon became known as the Karolinska Institute and is the forerunner of today's prestigious institution. This paper records the advent of the British surgeon who led surgery in the founding of this institute. This led back the topic of a report into the high mortality and morbidity rates due to scurvy which were sustained by the Swedish Fleet in Caribbean in the summer of 1800. This report, written by John Jamison, First Physician to the Royal Command of the James Ouseburn, was used by the Stockholm medical authorities as part of their campaign for improved training of military medical personnel. While Jamison's report did not in itself lead to the establishment of the Karolinska medical surgical institute, it was indirectly significant and serves both as an example of Anglo-Swedish relations during the Napoleonic era and a reminder of the origins of scurvy.

**Key words:** Royal Navy, Scurvy in the early nineteenth century, Swedish naval medicine, Karolinska Institute

#### Introduction

In the Admiralty files at the Public Record Office is a letter written on board HMS Victory at Copenhagen on 14 October 1801 by First Physician John Jamison to the Royal Fleet Commander Admiral Sir Isaac Sutherland. This

letter documents the mortality and morbidity rates sustained by the Swedish Fleet on the post-Copenhagen voyage that scurvy was the main cause of death and was responsible for the first physical prophylaxis. Jamison outlined how the disease should be treated, recommending a diet of well-steamed corn for the sick, and the use of fresh vegetables and lemon juice. A Surgeon's command, Jamison proposed a report based on his findings which was sent to Stockholm and read by the medical authorities as part of their campaign for an institute for the training of medical and field surgeons. The Medical Service Institute was the forerunner of today's Karolinska Institute and was established in December 1809. The purpose of this paper is to examine, as well as Anglo-Swedish relations during the Napoleonic era, to survey the impact of a single international physicians and to discuss more about the influence of scurvy in history.

#### Swedish naval medical personnel, 1788-1804

Sweden entered the nineteenth century with little understanding of the naval medical problem or civilian and military needs of care, a serious shortage of doctors and the need for a better system of medical training, especially in case of war. By 1800 the entire kingdom had less than three hundred medical personnel for a population of over six million. The fleet had 1000 surgeons. A few doctors did cover the medical needs of the armed services but pay was inadequate and retirement low. While some of them were dedicated individuals, the majority were men who had drifted into their positions in lieu of anything else. This situation was by no means unique to Sweden but it would have repercussions during the war of 1758-60 and 1808-9.<sup>1</sup> A document into the Parliament in 1741-2, which resulted in 18 1800 Hospital naval about three doctors alone.<sup>2</sup> Swedish vet. the response to most European wars in the

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eighteenth century which had "required their military physicians and surgeons to be qualified and often to spend more in part as commentators, especially concerned on military medicine." It lacked the formal structure and the political will to found a General Hospital or Dispensary for the training of political military surgeons and physicians. The Swedish navy like the army had suffered difficulties in recruitment of medical staff and coefficients resources. The Navy suffered especially from typhus, dysentery, scabies or the flux<sup>2</sup> and scurvy.<sup>3</sup> Although a naval hospital existed at Fleet Headquarters in Copenhagen it could do little to improve health and in particular could not cope with the epidemics which would account for more of the deaths suffered by the Navy in the wars of 1700-10 and 1800-9.<sup>4</sup> The single hospital after during the 1700-90 war was typhus. By 1790 75,340 were sick and in total 18,000 had died in Copenhagen alone.<sup>5</sup> The number of dead in the naval hospital between 1 December 1733 and 30 November 1789 was 3,423.<sup>6</sup> An Investigating Commission was dispatched in August 1789<sup>7</sup> in an report of 22 March 1790 a recommendation that doctors be recruited from abroad 140 were eventually selected from England. Even Russian surgeons taken prisoner were employed.<sup>8</sup> In 1792 a provisional border company school (filialskola) had been set up in Copenhagen to meet the Army's pressing needs for doctors in the Finland theatre.<sup>9</sup> A similar proposal for the navy went unheeded.<sup>10</sup> In the interim things went better managed. On 5 December 1789 Peter Almqvist (1760-1825) came to the Investigating Commission. At the time Almqvist was Director of the Medical Board for the Army in Finland. He studied the waste shortages of medical personnel and proposed a six month educational programme in order to produce border company surgeons (filialkirurgerna). This resulted in the founding of a surgical school at Stockholm.<sup>11</sup> One of the doctors known before that was Anders Hagström (1753-1800)<sup>12</sup> who in the next years will now was the mentor for John Jackson's report. The total number of border company surgeons produced throughout the area was 203 although 1 had been recruited the 340 were required for the Army and 300 for the Navy (140 for ships of the line and 60 for the amphibious fleet).<sup>13</sup> The rest of the war saw the closure of the surgical schools. The war left such establishments as unworkable financial burdens in peacetime. From 1790 to 1800, the medical establishment moved

de facto to reflection on medical personnel policy.<sup>14</sup> From 1797 the Collegium Medicum, the administrative body responsible for medical matters, was given the added responsibilities for the training and administration of all surgeons in the country but no extra funding was allocated. The organizational agencies were themselves at breaking point.<sup>15</sup>

#### Scurvy and the Swedish Fleet in 1800

On 21 February 1800 Russia invaded Poland. By April Sweden had lost several battalions of Vasaung ("Göteborgs infanteri") and Pomerania surrendered. The surrender of Finland meant Sweden had lost the eastern third of its realm and a quarter of its population. Apart from its naval victory in Sweden, Britain provided some military assistance. In May 1800 10,000 troops under the overall command of Lieutenant General Sir John Moore, had several contingents off the Gothenburg Roads but were unable to land where their commanders ordered. Gorden's order that they should consider the waters under Swedish command. The troops were withdrawn in July.<sup>16</sup> For the Swedish medical profession, the war of 1800-9 again revealed the shortcomings of doctors trained in medical delivery. Recruitment had not recovered from the 1700-90 conflict. Complaints in Gothenburg exposed the problems doctors encountered in a letter of 22 September 1800 to his colleagues Peter Almqvist. The Gothenburg physician Christopher Gustafsson wrote that the army had been greatly affected by doctors and that the commander-in-chief of the armed forces was trying to arrange for a hospital for 8000 men. But one of the Swedish flag ships ships was now a quarantine vessel that 23 men died in a week would on their way to Gothenburg that there was a "great shortage" (enligt brist) of doctors.<sup>17</sup> The fact of medical staff was such that by Royal order, high school doctors were accepted without even the six month training period that had been used during the 1700-90 conflict.<sup>18</sup> These flexible criteria were further relaxed as the war progressed and the surgical school at Stockholm was recruited.<sup>19</sup>

Sweden volunteered to assist Sweden through its Baltic Fleet under the command of Admiral Sir James Saunderson (1707-1804).<sup>20</sup> In May 1800, the Royal Navy blockaded the Russian fleet in the Gulf of Finland. In July the Swedish Fleet under Rear Admiral Pischkeff got to sea. However most of the crews were contaminated with scurvy and the Swedish fleet escaped. According to Nordhoff: "The sickness among the crews on

board of several dysenteries, which they called *Carbuncles*.<sup>17</sup> By September, Saurman reported on future steps he took to alleviate the situation.

Finding from Admiral Monckhoff that none of the ships were in a very healthy condition in the length of time they had been at sea and the want of refreshment, I recommended his directing, two of the ships of the line under his orders to Callisnoa with the most correct instructions to load breadstuffs and having sent Mr Duke, surgeon of the *Victory* to visit the first ships in Admiral Monckhoff's squadron and by having recommended to me that a supply of bread paste and sugar would be very beneficial, I have directed them to be supplied with these articles from the squadron.<sup>18</sup>

Admiral Duff's report is a graphic account of the scope of the problem and is worth quoting at length.

After a careful examination I am decidedly of opinion that many of the most obstinate and dangerous cases, observed (by sailors) of the whole fleet, in the months of January and February last, three ships were found out and have since that period continued at sea without having received any regular supply of fresh provisions, and the greatest part consisting of country butter, is generally acknowledged to be so vegetable diet, fully explains the origin and course of their present state. The aged persons which this disease is making scarce had to sustain the present state as already many hundreds of men have been sent to the hospital every hour in addition to the number of the sick, and as it is painful to remark that not less than four hundred have died by losing one ship more yesterday. All these men, which are various points can both for the cure and prevention of the formidable evil consistent with the want of fresh food have been suggested and put into practice with the utmost activity by the physicians and surgeons (many of the latter I am sorry to say, in Callisnoa have died). As the present proportion of late years with which they are supplied is insufficient to afford a radical cure and as much disease is manifested throughout the whole almost any measure to be required during the approaching season I am of opinion that every ship is to be apprehended from deteriorating under the stress of increasing duty.

It may not be improper to add that in this apprehension I do not stand alone: the surgeons of H.M.S. *Cornwall* and *Impregnable* perfectly coincide with me; and the Swedish captain is sensible of the antiquity of their ships under the circumstances already mentioned, and of the great necessity of giving into port.

P.S. Having visited the fleet again this morning I find the progress which the disease is making, even exceeds the opinion already formed, and if advantage is not taken during the present mild weather of getting immediately into harbour it is a ship under most excessively suspicious threat.<sup>19</sup>

From the British perspective the Swedish doctors aboard ship and others, influenced from longer<sup>20</sup> had done their best. However the Swedish medical infrastructure was not equipped to deal with a situation where every hour is adding to the number of the sick. Callisnoa had previously been agreed upon for the conclusion of the 1798-99 war. By October 1800, disease was rife<sup>21</sup> on:

The really condition of the remaining part of the sick ships under Rear Admiral Monckhoff rendered their immediate return to Callisnoa indispensable. It is a lamentable fact that out of the eleven out of the four which composed the Swedish squadron above five thousand men have been landed and the average of deaths in the 4th winter (Callisnoa) have not been fewer than from 25 to 30 daily, a melancholy proof of the inefficiency of these ships and their inability to have kept the sea.

Saurman's led by this, with placed his medical resources in the disposal of the Swedish fleet. As well as Duke and the other naval surgeons, the gravity of the situation was such that Saurman recruited the Fleet Physician, John Lawrence to prepare a report on the medical conditions of the Swedish fleet.

#### **John Lawrence and his investigations**

John Lawrence was born in Ashburton, Ireland, in 1776; the eldest son of Thomas Lawrence (captain's name in the First Fleet).<sup>22</sup> John Lawrence also served as a surgeon's mate and obtained his diploma in 1799. In 1802, after a number of appointments, this experienced doctor was appointed physician to the *British Fleet*.<sup>23</sup> In a letter of October 15, 1804 to Saurman, Lawrence stated that he initially found 1800 malnourished men, scurvy, confluent before decks with no fresh air. He noted that 1800 were instantly affected

where. The only intervention to me was surgery which caused lesions in scurvy that

Scorvy of itself is the most debilitating disease the human body is made to undergo to and recover when the disease is present can never cure it, and it could hardly well always recover the evil. I primarily recommended the further use of scurvy being stopped the flasks and Pott to be kept open, the patients to be removed from below and placed under the half decks. I strongly recommended a scurvy cure with a lot use of vegetables and Pott and Pott meat is, for in the space of three complaints would return of."

Lieut. Andersson had noted the advanced state of two Swedish colleagues. His numerous consultations of both men and a diet containing both vegetables and fruit were in line with those outlined in the Royal Navy."

The Swedish use of vinegar was, however, by no means a third treatment. "The practice of dipping the neck confined below decks and with its bottles, closed within the influence of Aired (air of 1780) who had held the office of physician in chief (overintendent) to the Admiralty in Copenhagen. In his 1791 report to the Swedish Royal Academy of Sciences on scurvy on the fleet during the 1780-90 was Pott explicitly and thoroughly noted that the medical food and treatment left alone stop was only one satisfactory effect of the cure. It did not of itself cause the disease. Admittedly scurvy is not that severe but the members of the sick would have surely included those and the attending doctors would have been in contact with scurvy. Pott's 1791 was on the health of sailors with this influence." It dealt with the representation of medical care aboard ship and where doctors concentrated on ships and their treatment, the importance of adequate nutrition, proper ventilation, clothing and hygiene. Pott stressed the importance of a varied diet comparing the British sailor's meals with those of other European navies. He was aware of James Lind's 1753 method on scurvy (scurvy cure) and stated that. Of all the diseases, this is perhaps the most dangerous for both Sweden and the people of other nations scurvy is the most common. However it was, while a disease which he believed could be kept under control. Pott's correspondence was followed by his "Handbook for Ship's Doctors" published in 1791. Pott's colleagues would have

agreed. Although he passed the use of both lemons, including lemon juice and vegetables. Pott was aware that such produce was more easily obtained for the fleet which operated in the Mediterranean rather than the Baltic. "The chocolate followed the recommendations of Cook" and advised the use of such was vinegar and seawater for the treatment and prevention of scurvy. "Spices were also recommended." However, whether that alone is an accomplishment, it is now known that such were effective. Thus, the Swedish approach to scurvy treatment was endorsed by the Swedish Navy and as the summer of 1800 was in large measure responsible for the decreasing outbreak of scurvy in that Baltic fleet.

It is interesting to note the correspondence between the medical officers expressed an interest rather than a rivalry. The above findings were already considered. The members of each crew from January a letter there were referred by Anders. Hagopian should be information supplied by Jernstam for his colleagues on the College of Medicine. Since October 1800 Hagopian already a professor of surgery in Stockholm had been appointed General Director of Hospitals in the month of April to September 1800 patients 3119 and on board ship were recorded as sick and 140 had died in Copenhagen hospital from March to November inclusive. There were 12,148 sick and 2089 died. These included those suffering from scurvy as well as dysentery and typhus, and included many of the real population. Hagopian, doubtless, acting on official instructions as well as on his own initiative, had requested Jernstam to prepare a report based on his findings which were sent to the medical authorities in Stockholm. By his correspondence with Jernstam in 1802 Hagopian sought its response.

The English naval doctor Jernstam, had in a letter made a direct appeal to the medical officers on the Royal Fleet at Copenhagen in 1800, and which has been brought to the attention of the government. "The King then through his secretary, on 12 April 1800 that I Dr. A. Hagopian Dr. Hahn, and one then chief physician Dr. Jernstam, should investigate these matters and in addition act, by an explanation and an investigation of the concerns in Copenhagen and therefore give a joint statement about the situation and the results that the above named doctor (Jernstam) has suggested measures for these diseases and that your own health will give a

argument as a result of his own investigation in May 1909 which him together with Dr Jansson's letter is attached. In the following of 1909 for order of the King a committee was to consider several schemes regarding improvements in the general medical care of the country.<sup>14</sup>

In regard to Jansson's report, Pehr Almqvist spoke his mind to his Gothenburg colleague Christopher Gullander:

I was recently called to Gothenburg to take part in the discussions concerning the conditions made by a Dr Jansson (act) the Service Director of Gothenburg's Fleet who undertook the medical care on our ships in Gothenburg but nothing seemed to me to mean any particular consideration and I therefore soon returned.

Jansson's (act) position certainly nothing but an illustration of the lack of facilities that we have with doctors for some time, and information about improvements that every doctor knows is necessary but cannot do anything about, not because of lack of knowledge but due to a lack of means. In these respects and history it is ignorance the Swedishness usually both doctors on doctors really considered and believe that these poverty equates with a lack of knowledge. They are willing to what we ought to do but do not consider what we actually know. In the above Jansson (act) goes in to show the means will give them part time and a lot of longer years, provide them with good beds and plenty of vegetables, that the hospitals should be well kept clean and provide people against facilities, and that every surgeon ought to be moved upon the service.<sup>15</sup> All of these one and who does not know that but how could it be done given our financial situation? It is only with great effort that we move forward in practice.<sup>16</sup>

To Almqvist what Jansson had to say was obvious and Pehr Almqvist went work on overcoming the problems medical education in the use of 1700-90 he was particularly aware of the dreadful difficulties that existed in 1809.<sup>17</sup> His views on the British were however decidedly positive.<sup>18</sup> Nevertheless, Jansson's efforts were sufficiently appreciated by the authorities as he was awarded the Order of the Vasa in July 1909.<sup>19</sup>

A year later sufficient support seemed to come Hagström on 4 June 1910 letter he was again charged to study measures as much as to publicly less perhaps the most, some plans to please mentioned persons who felt concerned (skeptical) by the explanations of Jansson's

report. This was also directed to the director of Clinicians who in the investigation of the Attorney General, had been the subject of an Advisory Board of Inquiry the previous year and had been examined.<sup>20</sup> Hagström advised that a war was because of other military medical management that seems had significant if existed in Clinicians, but that there was simply too many such to deal with effectively. Any measures of improvement were hindered. The use of doctors were probably undermined by Jansson's report which Hagström felt the authorities should get some satisfaction from so that the real result will be for the general good. Hagström also said that there is concern following for no measure where military doctor could be treated. For although he states that "there is nothing new to be learnt from this report" the importance of what Jansson has to say lies in his suggestions on how to make improvements.<sup>21</sup> On 12 April 1910 was noted after the deposition of Captain IV the project started that directly led to the formation of the Medical Hospital Institute.<sup>22</sup> On 24 May 1910 in Riksdag announced the establishment of

Medical Care Committee. In report was produced on 9 July 1910 and dealt with the proposal for the establishment of an Institute for the Corps of Royal Surgeons (Ordens Högskola för Sjukhuspersonal) in a document made available to the committee in October 1910. Hagström pointed out the necessity of establishing this institute as quickly as possible. The idea's declaration of was withdrawn on 1 November 1910 overruled his hand. Although Swedish names were Hagström and his colleagues used the same political situation's further push the government into action.<sup>23</sup> On 1 November 1910 the King's reply was promulgated and Sweden's Medical Surgeon Institute established.<sup>24</sup>

#### Conclusion

A Royal Naval medical report, written in October 1910 into the health conditions of the Swedish Fleet was read by the Swedish medical establishment as part of the efforts to persuade the authorities that an answer given for the training of military doctors should be seriously considered. The establishment of the Medical Hospital Institute in Stockholm might be regarded as a successful by-product of Anglo-Swedish relations although in retrospect not necessarily from this perspective not measuring the significant input from the

Swedish war experience through the Swedish contribution was an attempt to a valuable analysis for the medical and political historians. A case confirmed by war experience in the future dynamics of dynamic reactions and searching for the final issues of dealing with Napoleon which will try to this proposed relations with Britain over the course of the future of the

1800's. Jacobson and will Jacobson's work indicated that as the power of Sweden in Europe was diminished in conflict, a case for the coming of political union and naval support personnel was indicated. John Jacobson's letter his report and an appendix, also serve to highlight the historical changes of society and the influence of this document on history.

## APPENDIX

### Letter to the Secretary

(1800-1801) pp. 278-81

Her Majesty's Ship Victory  
Cantonment to October 1801

Sir,

Respectable to your direction, I have daily since my arrival here devoted my best attention to promote the recovery of the numerous Swedish Sick Seamen on Board these Ships, and in these Hospitals on shore. As it may be productive to further advantage I will take the liberty of stating to you the reasons I found these three diseases, cause of mortality and the means I suggested for their recovery. On Board these ships I found 1400 Sick all much affected with scurvy accompanied with Jaundice, low Fever, and a few Cholera complaints. They were all confined to hammocks without any bedding, placed in the cargo and men of the Ship forward close to the Mast, and the main deck, with the intention of keeping them from feeling atmospheric air. On examining the sick I was at a loss to account for all the symptoms. Patients being most in the early stage of the disease usually affected with bowel complaints, and every sixth or seventh man being less fit than, affected with dropsy and all appear sinking under general debility and dyspepsia, in many instances, increasing to emphysema, which too frequently terminated in the unhappy distress culminating around these circumstances led me to suppose the means they had used since the appearance of Scurvy on Board this Fleet. They informed me that having no other medicine, besides oil found them first of our scarce Mergol (cod-liver oil) as a poultice, that they had stopped the allowance of spirit, and had used the salt and sulphur Soap composed to drink largely and frequently of vinegar and water until they finally discontinued the use of restoring debility, bowel complaints, & dyspepsia. Scurvy I could not the more debilitating disease the State in body or mind is subject to and vinegar when the disease is present can never cure it, and if used largely will always increase the evil on these seamen, it dissolves the bowels, and scurvy is always ready to step in any part in a state of weakness and its spreading influence, and great tendency to profusely too generally proved fatal in two or three days. I strongly recommended the further use of vinegar being stopped. The Hatbills and Ports to be kept open, the patients to be removed from below and placed under the bulk heads, and all about every word allow it to be kept moving about in the open air. I strongly recommended a something diet, such a few men of experience and Fort and Port were as far as the nature of these complaints would allow of. In the Hospital on shore I found that suffering under similar diseases, they were much attended to the different boards, the windows well secured against the admission of cold air and few one of this was general. I requested them to keep open all the window and doors, being such low weather, and expose the Patients to the necessary breeze of pure, not bad smelling, clean air to walk about, so much as possible. I recommended the Patients suffering diet and ventilation and have a knowledge of the nature of being the cause of the bowel complaints. I have often day to day required such advice and successful remedies, that I am happy to say in final course recently stopped. As the number of sick have increased daily but the mortality has diminished within a few days to one sixth part of what they have daily lost since the disease appeared, and that those gentle means in saving upon my mode of treatment has been prohibited that, in my humble opinion, has children treated mankind, and the day before I took charge of them were almost despondent themselves. I am disposed to continue in continued-recovery and removal from air in the following course

of such depressing vision. In justice to these Medical Men I cannot help observing how liberality they have invariably suggested, and the cordiality with which they put them on paper, but how exhausted state their minds have effected the health of the greatest number of them. As the Swedish Service was in general discharged from the Naval Service during the winter, such a measure at this time would deprive the most happy remedy by allowing all the measurements to return to their respective homes, which would spare their minds and produce an economy which would soon destroy the influence of Scoury, and would enable them to accommodate such as required to return longer on the Hospitals, and to do their practice at medical treatment. Country air and sea would likewise be productive of the most salutary advantages in restoring their debilitated state. The Swedish Admirals and Captains of the Fleet have paid the most marked attention to all my suggestions for the maintenance of the health of their Fleet, and the means I have recommended to prevent such future calamity. They have expressed their strongest gratitude for the advice which you have taken to their heart, on this and every other occasion, and the assistance you have afforded them. And I must beg to observe the regretfulness of the Swedish Fleet entering into Port the more they did, as the disease has gained such an alarming height, and the means of curing it so bad that their fleet must have been soon consumed by its fatal ravages.

I have the honour to subscribe myself with every sentiment of respect

Sir

Your most obed<sup>t</sup> very Humble Servant

(signed) Dr Astruc, Physician to the Fleet



Reproduced from *Naval and Army Medical History: The memoirs of Sir John Roper*

In possession of the Sir John Roper Library

#### Abbreviations

- AJES  
 ID: Fife (ed.) *Australian Dictionary of Biography*, Volume 7, 1988, AJES Melbourne University Press 1987
- ADH  
 Admiralty Papers, preserved in the Public Records Office
- DSH  
 L. Stephens and S. Lee (eds) *The Dictionary of Australian Biography* Oxford 1998
- HSAG  
 (Hagaporters Biblioteket, Kungliga Institutionen)
- Lloyd & Coates  
 C. Lloyd and P. L. S. Coates, *Medicine and the Navy* (2000, 1996) Volume 81 (2004) 3825
- SHL  
 Lovagshuset, Förläggare, Svensk Bibliotek, Lunds

#### Funding

This work was financially funded in part by a project concerning the history of Karolinska Institute in preparation for its Bicentennial in 2010.

#### Acknowledgments

The authors wish to thank: Bengtsson, Commander P.H. Rask, Director, Institute of Medicine, Karolinska Institute, the staff of the Hagaporters (HAG) for valuable assistance in archival matters. All translations are by the authors.











# History

## A Brief Note on George Bass

Jane Wickenden

George Bass was born at Ansonville (New) in 1771, only child of George Bass and his wife Sarah Newman. He was six years old when his father died, after which his mother moved to Boston. Bass was apprenticed to a local doctor and in the age of 15, on 2nd April 1789, was accepted as a member of the Company of Surgeons. Within two months he was serving as surgeon's mate aboard HMS Flirt.

His next voyage was in 1792, George on a voyage to Botany Bay, an expedition organised which was intended to include a search for the Bass's whaler, but was on the real cancelled owing to delays in sailing. George Bass occupied the time in qualifying as a Surgeon 2nd Class (July 1st 1793) and was promptly appointed as HMS Flirt's surgeon the next three weeks in the Flirt's fleet in his spare time learning the art of navigation.

In 1794 he was posted to HMS Lizard and in 1794, possibly in his own request, in 1802 returned to HMS Flirt. Records of Bass's hometown of Boston were sending various new plants to New South Wales aboard Bass's fleet that had required no return as natural history. He was later (1799) elected a member of the Linnean Society. Also aboard Flirt was another Linnean, man, Matthew Flinders, both he and Bass were accompanied by John Hunter sailing with them to take up the post of Governor of New South Wales to explore the coast of Australia and then anchored.

HMS Flirt was not out at the end of 1794 and reached Port Jackson NSW in September 1795. On 20th October, Flinders (Bass) and his various William Murray sailed with HMS Flirt Bay, exploring the Georgia, Koor's (later Ballantine) was later founded New down prevented further exploration until 1796, when another coastal expedition was undertaken. In the year Bass turned his attention to the 1800s. Mountains sailed from Sydney but his

Jane Wickenden was Honorary Collections Librarian at the Museum of New Zealand Te Papa.

experience a voyage to cross ocean was deferred by lack of water. In the same year Flinders earned supplies to the Cape of Good Hope, and returned in April 1797. Bass, as did other officers, bought his own stock of a few and various Spanish Mares along the coast on which the Australian wool trade was founded.

The war in the northwestern tip of the east coast of Australia were unknown for the unplanned behaviour of their currents, and on Monday 1st December 1797 George Bass, with six naval ratings, set out from Port Jackson on a 70-ton whaler to investigate and survey the coast. By January 5th 1798 supplies were running low and they returned to port, having travelled some 1200 miles. Only when Bass's observations were placed on his return was it seen that he was here, passed between the mainland of New South Wales and Van Diemen's Land (now known as Tasmania) he had discovered the Bass Strait.

In the company of Matthew Flinders, Bass spent the summer of 1798 on the ship *Neyland*, Lieutenant-governor Van Diemen's Land on various on island visits. By now his health was failing and in May 1798 within three years of Cape Horn on the *Reliance*, he joined into Charles Bishop on the *Reliance*, carrying a cargo of supplies and oil. On route to China, Bass deteriorated and visited the Flirt later, in May 1798 Bishop sold both ship and cargo of supplies and they returned to England on the *Woodford* in July 1800.

Thus, just the matter voyage to the Cape of Good Hope, may have visited three countries in total, on his arrival in London the Admiralty granted him a post a mile long, which he passed having applied for a trading venture which included the purchase with Bishop of another ship the *Tea*. One of the shareholders in this venture was Francis Waterhouse, captain of Bass's mother ship HMS Flirt, in October 1798 Bass married Elizabeth Waterhouse, the captain's sister.

On 9th January 1804 Brown commanded by Charles Bredon and with three aboard on mauling vessel sailed from Lymington. Trade was shaky at first, and depended on scheduled trip to Tahiti to fetch west supplies for Port Jackson, and an extension of this to mid March, but in the end the voyage proved profitable.

Brown, anxious to make sufficient profit to return to England and open his wife-planned mother venture to take advantage of the fishing and sealing opportunities around New Zealand, into which had fallen off, and Brown was asked to run a cargo to South America, thus relinquishing the trading rights of Spanish merchandise, a dangerous

but potentially highly profitable enterprise. The *Albatross* left Port Jackson on 26th February 1804, another George Blunt and the ship were never seen again.

#### Seagoer

*Seagoer* (East Sussex) from George (1779-1829) is a fictional character of the people of 17th-18th Century. Melbourne University Press, London. Cambridge University Press, 1984.  
George from 1771-1829 is edited by John P. Roper, illustrated regularly David R. Roper, British Library, British Library/Cambridge 1982.

"For the management of the not very sentimental forms of imposture, these authors observe that it is necessary to arouse the moral sentiment of carnal desire, as well as the power of the human body to resist."

The first of these is studied by the various relations in the other sex, and appropriate correspondences, the spirit, the soul, the character, etc."

Napoleon George W. Moore / *man's imposture* / London: Pauline Tinsell & Co. 1882, p. 90

## Adventure and Travel

### My Story (The Truth About Robbie Island)

Robbie Robinson



The author

This is my first post in the papers recently about how I came to find Robbie Island. Well I've been asked to write, at length for the Journal of the Royal Naval Medical Service, about my last real thought I might take the opportunity to tell my story, the real story.

Let me tell you a bit about myself and how I found myself in the Antarctic. I've been in the Navy now for about ten years. I live in Devon, with my wife, Michelle and two children, Aidan 6 and Jack who was born the day before we sailed for the deployment. I joined HMS Endeavour in May 2000. I consider myself privileged to have served on Endeavour and because of the excellent living accommodations for medical reasons, the Antarctic. There will always be you may be thinking that how many can you then go back to and work the Antarctic. 100,000 people to be exact but more considering the billions of people that have lived. Endeavour departs to the South Atlantic every year from October to May doing the

Antarctic Arctic Summer Watch in the Antarctic area Endeavour has a few work, general surveying, creating various British and Foreign data Camps as well as performing various tasks for the International Antarctic Treaty Organization. It was whilst surveying that I happened upon this previously unknown island.

As well as surveying the waters there is a need for total monitoring in around with these surveys. A little thing that involves readings of the total heights are taken every half hour for approximately 10 to 40 hours. This was my reason for being on a small desert island in the middle of the Antarctic.

We set out in the lower. Good use of Endeavour's small survey instruments to find the best route to our operations. After about an hour's passage we finally happened upon an island in the area that needed total readings. As the James Cook had quite a large drift, LARCO H2000's 2000 and myself took a chance to cross the island and set it to a small but nothing up a total station.



Island view

As you can see from the photo there is a lot of snow on the island but that was my reason for the

First Officer Medical Services W A Robinson was James Michael Smith/James HMS Endeavour



## Book Reviews

### Evidence Based Cardiology Second Edition

Edited by Stefan Yusuf, John A. Cook, A. John Cook, Thomas L. Fahey & Bernard H. Chou. 2000. ISBN 0 7279 1495 5. 290. 950pp. + CD-ROM.

Evidence based practice has now been fully integrated into daily clinical practice and provides the basis for the recommendations made by the Cochrane Health departments in the form of National Service Frameworks and the NICE guidelines for clinical care. *Cardiology: an evidence based practice* has been at the forefront of evidence based practice. The past 20 years reviewing a multitude of clinical trials providing evidence for treatment and surgical interventions across a range of clinical conditions. The sheer volume of data is difficult to review and therefore continues to be produced as a bibliographical unit. Keeping up to date requires a great deal of time and motivation. *Just help* that is available to the busy clinician in integrating the evidence into daily practice has to be welcomed.

This second edition *Evidence Based Cardiology* has been updated to reflect a significant number of the most important recent trials. Although a huge volume the information was clearly defined clinical conditions makes reviewing the information easy and allows a problem solving approach where using the text as a clinical setting. It gives a clear and concise introduction to the concept of evidence based practice. It also provides a realistic perspective on the health economics to be considered when deciding on prevention therapies when applied to individuals in a large population group at risk of cardiovascular disease. An exciting overview of the grading of evidence is included at the beginning of each section but appears to be used differently to emphasize the importance of applying appropriate treatment from properly conducted large scale trials whilst avoiding overemphasis on non randomised trial data. The data is presented in ways that is of value to clinicians at both the primary and secondary care setting. It clearly covers the management of the significant risk factors of hypertension, lipid, tobacco smoking, alcohol and obesity and stresses at both the primary and secondary prevention of cardiovascular disease. The evidence for best practice in the

therapy of established valvular, heart failure, heart failure, cardiac rhythm disorders and thromboembolic disorders is clearly presented.

I have used the first edition of this book since its publication as a reference for deciding on clinical care in daily practice. The accompanying CD Rom agrees with this edition will speed up access to the information at clinical or primary care offices. The prospect of a PDA version adapted on the CD will bring the data directly to the bedside and can only improve the provision of best medical care to cardiovascular patients. This updated version which can be regularly updated from the linked website should be considered as essential reference for any clinician involved in treating patients with a at risk of cardiovascular disease.

**Stephen Commissioner M. B. Stewart Royal Mars General Hospital-Cardiology and CCM**

**Medicine under trial by Zachary B. Frobenberg, New Institute Press, Annapolis, 2002. ISBN 1 55754 297 1, p. 172, £28.50 plus Clarendon Publishing 2002. ISBN 1 85176 217 2.**

This lively book is not aimed solely at the medical profession and although written by an American cardiologist, beyond the author almost complete lay knowledge most the final chapter.

The book takes a very balanced view, is well written and convincing to those with a slight interest in the history of medicine, medicine, or in well informed, it has a good bibliography.

Zachary Frobenberg considers the impact of cardiovascular medicine on the history of medicine at one, specific disease, such as coronary heart disease and rhythm, the three major hypertension and pneumonia, diabetes and coronary and finally recent medicine in the United States.

He covers both medicine and non-medical aspects of the practice of medical professionals of all professions helping disease prevention, clinical conditions and injuries as well as the appearance of these aspects and the American and that was before the battle started. He is perhaps, too harsh on the captains as posed as could imagine such still in the Dark Ages and

some hospitals had a better idea of hygiene than their medical advisors.

Well worth buying for those of you who wish to understand just how big is the medical service of a navy.

**Nick Baidock**

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**Approved For The Approver:** a guide for doctors, by Ruth Chambers, Gill Bailey, Karen Ford and Simon Ellis. Radcliffe Medical Press 2000. ISBN 1 85179 982 6. pp 200.

**Approved to read:** a text paper on the Royal Naval Medical Service. ISBN does it in its work CYPD Q&A's. revlutions et al?

I read this book just before a training day on an approval and was pretty glad I had done so as I was unfamiliar with many of the terms which trip all the tongues of my colleagues, who have occasionally mistaken general practice.

The book explains thoroughly and logically the reasons for mechanisms of processes and benefits of approval and can only give the doctor being approved to the approval the necessary tools to make a sound list of it. Use this paperback in conjunction with the guidance from your own college, or faculty and you have no reason for optimism, the prepared and most preparing now.

An essential publication for every practice but clean your own copy down.

**Nick Baidock**

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**When Malaria Ruled** by Peter Jones. Robert Hale, London 2002. ISBN 0 7090 6616 1 pp206. £19.95.

The author worked on the NHS for many years and then read for a PhD in health studies. He vividly describes the evolution of the hospital system and the struggle to overcome the problems of both the medical profession and the untrained nurses. By historical gaps, personal recollections and anecdotes, the role of the hospital system is fully discussed (including the hidden of money) and the nature of the Q&A's are discussed.

The Roman report and the rapidly evolving

NHS saw the doctors of the traditional hospital system work for historical reasons of money. The author points a convincing picture that the NHS was an overwhelming success and will continue to be. The NHS Plan, Modern Medicine, 2001, they reduce some of the deficiencies.

I would recommend this book to nursing literature and doctors of a certain age who view their early hospital careers through rose tinted spectacles. Modern medicine, whose training can appear to stress the physical care of the needs of patients, would profit from understanding these lessons.

**Nick Baidock**

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**Unsettled** by Roger Paul Ashby Q&A. Pica Publishing 2002. ISBN 01976 8020 1 pp206. £19.95.

I first encountered Roger Paul Ashby when he appeared before the Medical Board of Surgery, his account of his experience was limited and understated. I read his book when it arrived for review and sat up at the early hours of the morning as I was totally impressed.

He mentions his childhood experience, training in Leamington, looking for a degree at Cambridge when he could spare the time from climbing, jumping or travelling round Sportholm. His account of Mountain Guide training is not for the fainthearted.

He volunteered to be a Military Observer attached to the United Nations in Sierra Leone and afterwards first found the vacancy of the Royal Army and the capability of some UN components.

Forced to take refuge with a company of Kenyan soldiers (whose power he sought to eventually escape through the following RUF) and as an eye of Europe and common and eventual resistance from soldiers of Sierra Leone reached safety.

The story in the end is that as a subsequent appointment in Victoria Island he developed the first symptoms of post-traumatic stress disorder, mainly through the positive in the cockpit.

I highly recommend this book as a good read, as an insight into life as a young Royal Marine officer and as an account of overcoming adversity in many forms.

**Nick Baidock**



## Obituary

**Baroness Vice Admiral Sir Eric Bradbury  
KBE, CB, CBE, FRCO, HonD**

*In the service of humankind, for the life of Sir Eric Bradbury who died on 6 January 2002 Sir Harry Wain gave the address*

That great humanitarian physician of the late nineteenth century, Sir William Osler believed that the most distinguishing feature of a successful university of doctors was reputation in the physician or surgeon, he said, no quality other than with impartiality for that job brings accolades and presence of mind under all circumstances. calm mind calm and clarity of judgment is to survive all great pain. They were qualities possessed and exemplified by Sir Eric. In doing, many like me, honour today, and my dearest memory of him is of his placid disposition as a variety of personal and administrative demands which required that this cerebral and sound judgement would prevail whenever the nature of the challenge.

Eric was essentially a person of reason, calm and processes untroubled in complexity, with a quiet but keen sense of justice. He was an honourable judge of character which made him a great deal when he became Medical Director General, for it ensured that the right men were promoted. He was patient in his work and his twinkling eyes betrayed a sense of fun enhanced freely within the intimacy of family gatherings, but also in the patient hospital which he and his, his charming wife so warmly provided in their delightful home. Eric as he had to remember, for the office and quite untroubled the Admiralty's medicine when Eric became Medical Officer in Charge of Naval Hospital in 1941, bringing the Institute of Naval Hospital and laboratory never before seen.

They complemented an another probably Eric, elegant, precise, cultured and outgoing. Eric, always with a strong sense of humour and a shared sense of character. Both were well educated, required conversation, and readily wit over their countries, given, many of whom were concerned professionals who, under the Bradbury spirit, subsequently supported naval medical systems. I remember for example that when Francis Alexander visited Blandford while response was clearly observed and the function,

especially the strong influence of Eric and his quality developed humanity and the social systems simply became one of us. They were the perfect couple, simple, principled and exemplars of a humane family life, allowing their three daughters and family group of the 12 families. Eric and Eric were inseparable and he was devastated at Eric's death yet here again, he demonstrated the character Sir William Osler had valued so highly. My dear and Eric has been to embrace such a measure of humanity, as to be truly when the city of wisdom and good came to meet a with the courage facing it was. There is an unbridled to measure, Eric's bearing and dignity in Eric's heart will have been perfectly be retained in a objective.

Eric was born in Norfolk and attended Queen's University Belfast where he took his medical degree and was captain of both the team and rugby teams. They were sports he enjoyed throughout his life and, as long as he was able, he remained an enthusiastic supporter of the naval Army and Navy rugby which. In 1931 he joined the Navy following the tradition of two of his father when he, strictly rejected one of whom had been Captain Vice Admiral at Blandford during the Second World War. From 1933-1935 he served as an HMS BATHAM a Queen Elizabeth class battleship, later transferred to the Mediterranean with heavy loss of life, then HMS ENDLAWORTH and the combination County class cruiser HMS CUMBERLAND. We can have an entry given in the Mediterranean on board the cruiser CHARLOTTE concerning his and subsequent service, before joining the hospital ship COMFORTHABLE. For a time, after the war he was employed in the Medical Department of the Admiralty when one of my colleagues, Sir John Murray, recalls Eric's warm greeting and spontaneous hospitality when he first arrived in a young recruit. Eric was a Consultant Radiologist. Eric served in naval hospitals at Blandford, Portsmouth and Malta.

It was at the Royal Naval Hospital Plymouth that I came to know Eric, well. I was a Consultant Surgeon and the Consultant Radiologist. We had at that time a very busy vessel and other complicated processes and I spent many hours with him evaluating critical details on X ray

time and decreasing their engagement. Eric was knowledgeably, highly professional and perceptive and I came to place the greatest reliance upon his opinion and to value him as a friend and confidant. It was then not that I felt exposed to the wrath of Eric and his hospital.

In the early years Eric, then a Surgeon Captain, was appointed Director of Naval Medical Staff Training a position for which he was ideally suited with his youthful enthusiasm, his interest in individuals, his sensitive temperament and his and his reforms and he is remembered by his officers for his energy. It is therefore hardly surprising that under his reign the old but hard kernel of the Navy was transformed into the modern Medical Branch with qualified specialists in major disciplines forming a group of Medical Technicians affecting busy weekend men to pay and more. Promoted to Surgeon Eric Adams in 1956 he was appointed Medical Officer in Charge of the Royal Naval Hospital Hader and Naval Medical Officer to the Commander in Chief Naval Home Command and was made Honorary Physician to the Queen and Commander of the Order of St John of Jerusalem. In a sense it was the apex of his career when he and his staff, as well as a detachment of many others provided the basis of the modern Royal Naval Medical Service which they did so much to encourage and sustain him by that was very much in control of things. He was clearly where the Service should go and he used carefully crafted speeches to drive his message. They were always measured and he dispensed with ruts.

From Hader promotion to Surgeon Vice Admiral and Medical Director General was a natural step and enabled Eric to consolidate the

advances already achieved. It preceded with my own promotion to Surgeon Rear Admiral and Dean of Naval Medicine, responsible for setting up the Institute of Naval Medicine, and appropriate medical training. It brought a close working relationship in which Eric was unstintingly supportive and encouraging, so that by the time I succeeded him as Medical Director General in 1972 the total transformation of a modest professionally competent Royal Naval Medical Service had been almost total.

After his Service career Eric and Tola settled into their charming home with its delightful garden at Bucklebury Wells and I hold cherished memories of previous weekends shared with them there. But even in the style of service Eric found a responsibility which he equally accepted and responsibilities. He became an inspiring Chairman of the local Health Authority refusing a salary in thanksgiving, for his presence was giving the war. He founded Wings in Home and became its President. He took an active interest in Sea Cadets and remained an examiner in the Air Cadet Selection until his eightieth birthday. Then, Tola developed her personal affairs and three devotedly cared for looked for her and cared for her until the end when he was present at her passing.

A fully rounded man, he faithfully followed the advice of Polonius in Hamlet the young Prince of Denmark.

To those who will be true and a great father-in-law the night the day that came not then to him in any way.

Those of us who have had the privilege of knowing Eric will working with him of sharing his thoughts and his friendship and of copying the humanity which he and Tola so graciously offered. I therefore end my words with great affection and who was truly and deeply loved.

## Obituary

### Lieutenant Commander Norman (Nick) Carter

Lieutenant Commander Nick Carter died on 27 July 2003 after a long illness. Lieutenant Commander Henry Page writes:

Some time ago, long before all health overtook him, Nick made an appointment with me that we would each prepare a eulogy for the other. The two of us probably predicted that this would almost certainly be a one-sided appointment and, meeting Nick a somewhat dry sense of humour I can hear his spirit saying to me "What, look, Henry, you first!"

Indeed I have lost so here we all feel I look back with pleasure at the time 4 years ago when our paths first crossed. Two completely green Royal North Australian sailing passages in 1955. Norman joined the service in the Far East and the Korean War where Nick was in post-41 Independent Commando Royal Marine. This experience left him with an indelible interest in the activities of the Royal Marines and brought him many long lasting friendships in the Corps.

Before he went to Korea, Nick was serving with Infantry Battalion and in the mid 50s he served in 1959 Cheshire and HMS Hobart. During the latter time he served in LCY 4545. Two years with the Gloucestershire Regiment started him a year before in a hospital job before the call of the deep-sea took him back to the Far East on HMS Lian. At that point, in Singapore in 1962, our acquaintance was rekindled. I think would understand my young first world and his war. For the first time Ann and our 7 year old daughter Alison. From that moment he was adopted as Uncle Nick and 18 years later he played an important part in Alison's wedding. Today Alison is able to appreciate her love and affection.

Nick's career's longest duration was his time in Laos where he was selected for promotion. He was commissioned in January 1964. Inevitably he became disappointed and the nature of his and my status brought us great closer together in the following 10 years. He served in Laotian on Chomphong in February 1964 after

working in Royal Medical establishments in Hong Kong and the Highlands. Once again the MOD did not have him because he became the Manager of the Medical Wing at Hong Kong where he spent his undoubted managerial and organisational abilities to good effect until the hospital closed in 1969.

The second half of the last decade was a turbulent period for him but, being the superior operator, he overcame his disappointment slowly by dabbling in Art sales and, being even more systematic, as a Wildlife Cameraman in Devonshire. However these were, I suspect, less sincere than the acquisition of a Nick and Phil Protection upon which he lavished much loving care and time. The eleven, together with the first, the Miss Moon, a service finished many years, offered him a family where he needed one most, though an unwanted period to a happy conclusion. Nick found peace and contentment and, as it happened, a woman to love who gave him all the intimacy and love, possible during his illness.

Ann and I are grateful for the fact that our first passage in Plymouth has allowed us to share many happy hours with Nick in the past 4 years and our membership of the Sea Country cell of the Royal Naval Medical Branch Kingsland. Nick North Sea's Association provides its members daily link between that day in 1944 and the moment now when we say Goodbye to him. My own memory will always be of a good friend, a man who was cool, steady to offer a helping hand, and who was generous to a fault. I know that he would wish that his old commando policy as a collaborator of a full scale withdrawal from China to Laos, was for Nick.

*He lived as you when friends are dear  
Perhaps, well over a night a year  
Then said we are your truly serving*

*Chorus: dear you, dear  
My old "Good night" And to some tonight a tear  
Before Good morning*

## Obituary

**Surgeon Commander John Miles Fitzpatrick  
RMS Royal Navy**

John Miles Fitzpatrick (usually called Jack) was born in Dublin on 13 October 1911 the youngest son of Captain T G Fitzpatrick, Royal Irish Fusiliers, who was killed as a pilot in Canada in WW1 having been stationed in Despatches whilst on the war.

After the Atlantic Hospital and the Royal College of Surgeons, Dublin Jack joined the Royal Navy as a Surgeon Lieutenant in 1938, being appointed to the cruiser HMS *ENTERPRISE* in the same year. The ship was based at Trincomalee and cruised the waters of Ceylon and the Indian Ocean. During this campaign they gave passage to the heavy cruiser *Black Prince* and her company for part of the voyage to port in England. When *ENTERPRISE* had been in sea for two days an enhanced illness struck on board, as an log a message of Jack going to the hospital from the people of Singapore. Jack's own ship was HMS *DIAMANT* (1939-40). These jobs were continuous with temporary officers and on our return, when his ship was docked, as Allen for a while, Jack took local leave to work as a paper editor as experience that he always required.

He joined HMS *FORBES* of the 8th Destroyer Flotilla on tour for the outbreak of the second world war. As soon as they the outbreak, when the Flotilla entered the North Sea, they were passed very close by a large *Wunderland* Lloyd last parked to the perimeter with German troops. On the Declaration of War the Flotilla moved and moved on the way for the campaign but failed to find her. (Lately, said Jack).

Later this year, upon receiving the North Sea they found a survivor from the aircraft carrier HMS *COURAGEOUS* clinging to the sea, several tons and with him with them back to Royal *FORBES* had been badly damaged by bad weather and while old was undergoing repairs at Royal Dock, many months to HMS *PRINCE* to help her return to the Surgeon Commander (then Surgeon Captain) W G C Fitzpatrick, Royal Navy, on up the last three months of his life in this country and it is followed as Surgeon (A) and had been reported by some German working in South America.

For this pioneering work as a permanent medical W G C Fitzpatrick was, entitled the *Golden Star Medal*.

Jack then went to the Hospital Department of the Ministry of Health, for several months and where there was a lot of emergency surgery to be done in the early months of the War. He then joined HMS *CONCORDE* based in Fremantle and later made diagnosis, radiology from the PMO Surgeon Commander Reginald West (1940-41) and the RNVS.

He joined Combined Ops on his return to the UK and had three months in London until leaving London for the Welsh Army where he was in the New Zealand Division (Island) Bay Scouting, he was later the other main medical officer being the temporary Surgeon Lieutenant "Liz" Austin. They were the only surviving MBIs now, as he was able to put up as a "on their campaign officers".

He went to Berlin soon after the landing of May 1941 and on up and into a Casualty Clearing Station and a general Field Hospital in three places. He was very interested when a *Quakers* was sent a dozen for and was all the *Canadian Contingent* Training Centre for a day. In March 1944 he was posted to RN Auxiliary Hospital, largest Aberdeen in the North Sea. Then in November 1945 to HMS *ROYAL ARCHER*, the RN Training Establishment first in Surgeon then in Captain, Walsby, taking a posthumous phly when promoted Surgeon Commander and PMO to HMS *CORBIN* Light Fleet Carrier based in India, in November 1947 after her former PMO died suddenly. When *CORBIN* came home he did maintenance in 1949. He joined her once again HMS *COLUMBIA* and went with her to Hong Kong (in PMOs) and eventually in Malta upon returning to the UK in May 1950 and taking the British Main Maritime Unit around Scotland for some weeks later that year.

He was a *Royal Special* in HMS *VICTORY* in 1950, then did a six months post graduate course in Radiology under Professor Scobie in Queen's Hospital from October 1950 to April 1952. Sally Phyllis was his work output and he failed to gain a Diploma in Radiology. He was a *Royal Special* in HMS *PRINCE* until June 1953 when he was appointed PMO

of the carrier HMS LORCHAM, this death being recorded in July when the Russian War ended.

In January 1964 he joined the Royal Naval Air Service, HMS DANIELLUS, initially, but on board in February 1965 to be PMO of HMS PLYMOUTH, AND, voyaging to the Far East in the summer of 1966, he came home to HMS DRAKE, where he was X-ray Specialist for three years, leaving much more for the Far East in January 1968 to HMS THUNDER. He was given permission to work in the South Asian Tuberculosis, Abdominal Chases, voluntarily as off-duty hours, during most of his eight-year months in 1969, TIGER. On returning he was appointed X-ray Specialist in HMS FRANKFORD, where he continued until reaching retirement day in 1966. It was during these years that he also worked for HMS GANGES for the Royal Marines at Deal and for the Army at Sherwood's Barracks. He was delighted to be offered to continue his naval X-ray job as President but as a Civilian Medical Practitioner, driving through the Man/State or various obstacles, and being denied by the Gate Guard as formerly, he was made an Honorary Member of the Warham Moor and as well as running the X-ray Department he worked general medical duty nights and weekends, often covering for young staff doctors. He also enjoyed doing it every Thursday and on Special Guard Nights.

As work rapidly diminished "with the dwindling Navy he began to work in a small local General Practice, gaining experience" he

said. He was also employed part-time as a Consultant Radiologist by the NHS, although he never obtained this title for himself, having failed to pass the DPMPT.

He was Chairman, Exeter, close to 1982 and 1983, then moved above in 1983, he and wife undertook doctors and their work as being the best people to leave the X-ray Department. He attended the Royal Act of Winding up St George's Church in 1983.

As a young man he had enjoyed sailing and pool, climbing and had played hockey once a year. He played for the Navy when, to Royal Arthur and for the Winklesham Moor in 1960 and 1961. He played again and he was only tried and for the Underwater Medicine Course, where he was very busy. He was appointed OBE in 1982.

After falling downstairs (he had the) when he was eight years, in November 1943, he suffered a prolonged silent and painful and was hospitalized for seven weeks. He would eventually along fourteen months to heal. This finally enabled him to pick up work and to spend his first night, and a half, peacefully at home, a delightful companion to his family. When he was well enough he returned to work in the garden, working the rocks built their own, at the bottom, starting to not be the garden shed.

He married in 1946 and is survived by his wife and daughter.

**Eric Fitzpatrick**

## Obituary

**Surgeon Commander (R) E. H. C. Cliff OBE**  
Royal Navy

Irwin Cliff was born in Morden on 26 September 1928, the elder son of E. C. Cliff, CBE, a senior Civil Engineer in the Air Ministry. He died shortly after his 73rd birthday while playing a round of golf.

Irwin qualified in Science University, Belfast, and joined the Royal Navy on 26 September 1943. After a short spell in HMS DRAGON he served in HMS CYCLOPS, depot ship for SM7. His next commission was in HMS BONAVENTURE, where he accompanied the Captain (M. B. Pells) as 'the most efficient and learned Naval Dental Officer I have met in my career'.

There followed appointments in HMS TORPOR, MERCURY and CHARLES. He joined HMS BACCHUS in 1953. At this time he became the first Naval Dental Officer to gain by examination the Fellowship in Dental Surgery of the RCSI (Edg). He was selected to represent the senior Naval Dental Officers at the Commission

proceedings of 1953.

Irwin was Fleet Dental Surgeon at Trincomalee from 1955-1957 and was promoted Surgeon Commander (Ed) in December 1956. He joined HMS HINDUS again as Senior Surgeon in 1958. An appointment to SOCS, HMS TULPOUR, was followed by three years as the Admiralty Dental Chief.

He was awarded the OBE in June 1964 shortly before he joined HMS Physiotherapy Consultant in Dental Surgery. His pioneering career was cut short when he was involved in 1967.

Those who knew Irwin will remember him as an enthusiast for all the qualifications that are of dental importance by McDonough and Benbrook in his spare and keeping fit. He was an early follower of the teachings of Surgeon Captain F. L. Clifton on the importance of fitness in the dent.

Irwin's youngest brother John, who practised as a Dentist, was one of the first Naval Physicians to be appointed Consultant.

R. A. Trewin

Notice has been received of the death of Surgeon Captain E. H. Marshman OBE on 19 December 2002 and Surgeon Captain L. DeWitt on 7 February 2003. Our condolences go to their families and friends.

The editors would welcome any words in their memory.

### NAVAL MEDICAL COMPASSIONATE FUND

The NMFV was set up to provide benefits to the widows and orphans of Naval Medical Officers. Currently a grant of £2800 is payable. On the Acute Care? Why not subscribe?

For further details contact:

The Assistant Secretary  
Naval Medical Compassionate Fund  
Room 114 Victory Building  
454 Naval Base Portsmouth  
Hampshire PO2 1LS  
(01703) 62 723441

## Service News



*Presenting a Medal to Surgeon Captain, RNVR*

*On 16 September 2002 Commander Peter G. Matheridge, a Royal Australian Fleet of History, the Assistant Surgeon General (HMS) of the Australian Fleet, presented a medal to a man in the Royal Naval Medical Service. The medal will give the holder a history in the history of Naval Medicine. The article on page 127 gives a brief history about this.*

**Clinical Consultant to MED(N): Mr B G G**  
Second MB FRCS (Surgery)

### ROYAL NAVAL MEDICAL AND DENTAL OFFICERS

**Naval Surgeon**  
Order of the British Empire Surgeon  
Commander O E D Howard

**Appointments as Consultant Advisor**  
Surgeon Commander Cdr C Sykes (Ophthalmology)

**Appointments as Consultant Advisor to MED(N):**  
Surgeon Commander J M Hammond  
Oxford South Medians

### ACADEMIC ACHIEVEMENTS

Surgeon Commander A R C Allen  
MBChB

Surgeon Lieutenant Commander L B Connor  
FRCS (Orth & Trauma)

Surgeon Commander M R Goss  
FRCS

Surgeon Commander N Fisher  
MB

**Surgeon Lieutenant C J George**  
**Diploma in Medical Care of Cadetships**

**Surgeon Lieutenant S M Jenson**  
**MBB, FRCPs (Paed)**

**Surgeon Sub Lieutenant M R O'Shea**  
**MBBS**

**Surgeon Lieutenant Commander S Parke**  
**MBB, OGE, DFFP, JCPDG-P-Cert**

**Surgeon Lieutenant Commander S L Shaw**  
**JR, FRCP-Cert**

**Surgeon Lieutenant Commander S R C Rogers**  
**Final FRCA**

**Surgeon Lieutenant Commander J B Smith**  
**MRCP (Sports Med),**  
**Diploma in Sports & Exercise Medicine**

**Surgeon Lieutenant Commander S R C Smith**  
**FRCS (Orth & Trauma)**

**Surgeon-Commander S A Sopley**  
**FRCS (Orth & Trauma)**

#### PROMOTIONS

##### To Acting Surgeon Lieutenant

**H E Bentley**, A M Dewdney, D R C Gordon,  
 R P Gilmartin, J J Horton, S C D Jopson,  
 C B Hume, M H Lashley, D M Montgomery,  
 S W P Muddiman, D L Harris, M J P Norman,  
 L R Paylor, S P Peggibly, P G Peck, Barrow S,  
 D S Sargent, A J Skarvane, R P Thomas,  
 A M Wood

##### To Surgeon Lieutenant

**D C Allcock**, R E P Ambler, N B Barker,  
 M A Davies, A M Edwards, T G Evans,  
 B Hennessey, C B Hunter, R J Kershaw,  
 J C Phillips, C R Polson, R S Taylor, A J Vale,  
 R W Westerman, A M Wood

##### To Surgeon Lieutenant Commander

**I M Butler**, J J Girdlestone, W A M Daw,  
 M P Henry, S D Houghs, I D Mervin,  
 R A L J Peck, J Rissman, P S C Ross,  
 S L Shaw, L A Whybourn

**To Surgeon Vessel Admiral**  
**S D Carr**

**To Surgeon Vessel Admiral**  
**T L Jenkins**

**To Surgeon Lieutenant (D)**  
**G J M Smith**

**To Surgeon Lieutenant Commander (D)**  
**W S D Church**, T C Davis, A J Hewitt,  
 S L Invernizzi, R B Vennart

#### NEW ENTRIES

**Cadetships Surgeon Sub Lieutenants**  
**C S Bell**, C J Blandley, R M Booth, L B Mayle,  
 T G Bingham, R L Davy, A M Dewdney,  
 R T B Davies, D A Gordon, S A Hume,  
 R J Jones, O B Roney, R J Williams,  
 I M C D Wood

##### Surgeon Lieutenants

**C M C Brown**, R S Taylor, P J Williamson,  
 C B Wilson, I M Phillips

##### Surgeon Lieutenants (D)

**R J Shaw**, J P Webb, D Williams

#### DEPARTURES

**Surgeon Lieutenant Commander (D)**  
**P A Marshall**

##### Placed on Retired or Reserve/Agency Lists

**Acting Surgeon Lieutenant R P Hume**  
 (transfer to RAF)  
**Surgeon Lieutenant (D) R S Woods**, S W  
 Janssen  
**Surgeon Lieutenant Commander S J Chubb**,  
 J C Grews, N A Morgan  
**Acting Surgeon Commander J D P Hudson**  
**Surgeon Commander (D) S J Luggs**  
**Surgeon Commander P J Crawford**  
**R P S J Carr**  
**Surgeon Captain D A Cunningham**

##### From Veterans

**British Dental Association Armed Forces**  
**Group Dental Educational Training Audit**  
**Project Phase 2001 Surgeon Lieutenant (D)**  
**S L Southall**  
**National Financial Services Vocational Qualification**  
**Practitioner Award 2002 Surgeon Lieutenant**  
**(D) G E Bryant**





## Blood Red Dinner Speech 2002

The Annual Dinner of the Royal Naval Medical Club was held in the Painted Hall of the Old Royal Naval College Greenwich on Friday the 19th September 2002.

Surgeon Rear Admiral Ian Jenkins, the Medical Director General, presided having welcomed the guests to the dinner.

The story of a Royal Naval Medical Club was suggested by a group of medical officers having dinner at the Officers Club in 1911 and the first formal dinner was held in the Princess (Barracks) (Probably in November 1911) to May 1914 the guests were Prince Louis of Battenberg, R. V. M. (Vice Admiral Sir John Jellicoe). The dinner ceased during the Great War but recommenced in May 1919 in the Taverners. In 1930 it was agreed that every medical officer serving at naval hospitals or messes (should be eligible to join and in 1952 dental officers were included. Changes reminiscent to the Royal Navy were included at the Club (Membership in 1966. Dinners were discontinued throughout the Second World War but resumed in April 1946. The Royal Highness Prince Philip (Duke of Edinburgh was the principal guest in 1976 and in 1986. Senior medical and dental officers were invited to join QARMS officers became eligible in 1981 and now membership is open to all Medical, Dental, Nursing and Medical Services officers of the Royal Navy (RN), RMN and QARMS and QARMS (R) and our civilian consultant colleagues. There is another milestone in the Club's history being the first occasion when invitations have been extended to include spouses and partners. Traditionally the Painted Hall of the Greenwich Naval College became the main upstairs library and it is now used on alternate years.

Charles II (planned to build a great palace in Greenwich. Work started with Sir King Charles II, which was well advanced in 1664 when he set out of exile. Louis XIII proposed that the growing buildings be served into a great hospital for women to assist them in Childbirth and delivery. The work was undertaken by Nicholas Hawksmoor who had been a pupil of Wren. It was in the Painted Hall of Greenwich Hospital that the English navy was created in 1688, that year King George I on the 28th of September 1714. The Hall had been designed by

Sir James Thornhill and represents British sailors over France. It is said to be a magnificent tribute to William III, the great founder of the Whig monarchy and Britain's adopted, catholic monarch of British will, confidence and ambition based on strength, sea power and undivided service. Royal Naval College Greenwich opened 1812 and closed just a few years ago.

Commensally the Blood Red Dinner has been the occasion for the Medical Director General to give an annual state of the nation address. You will undoubtedly be glad to know that I challenge have my mission of doing that. I am deliberately not focusing on our undoubted achievements in medicine during the FLEET Argon on deployment in Sierra Leone, Sierra Leone, Afghanistan, the Balkans, Northern Ireland or at our work in deep submergence and with the Royal Marines. These missions have been outstanding success but we must, hold forward in the future. The world is variable in pace and it is undoubtedly true that any deployment of British military units, by sea, land or air will demand our professional support.

Defence medicine however is in an interesting point. Potential enemies will change as we have witnessed over the last 15 years and very rarely more recently and new threats will emerge from other nations, regions, terrorist, diseases, and pandemics. There will be new requirements for humanitarian and disaster relief medicine, possibly of greater magnitude in world climate change. Undoubtedly there will be new weapons systems, conventional or otherwise, producing new patterns of injury probably not realising that there is a fairly healthy population. New combat systems will be developed bringing with them a need to develop new applications of physiology, the control of weapons and under water hostile attacks are further explored. New technology will bring new understanding and will demand new medical countermeasures, yet to be contemplated. Historically military medicine has been compartmentalised but this risk is likely to recede and new models of interdepartmental and personal partnership will be needed, similar to the new divide will physical fighting with computerised support and this is the interest or will welcome for

acted by non-continuous waves, such as electronic electrostimulation or cyber weapons? What is certain and is of potentially relevance to all electronic forces, such as this is that participants in changing. People may no longer be required to face the military risks and sacrifice loss of their life here and the general public will rightly expect the highest standards of clinical care and governance. Innovations in warfare will bring new stresses which may be misinterpreted but will generate their own new stresses and post-traumatic, cytopathology. Telemedicine will be increasingly available for remote diagnosis and treatment, the extensive communication of clinical parameters and instant medical second helping. We face the exciting opportunities of responding to all these new medical challenges.

Although not a part of the recent address, I wish to make my huge personal gratitude to the men and women of the QANHS as my cousin as Medical Director likes to say it. It has been an outstanding privilege to be the leader leader of such a group of skilled professionals, who are as used to forward military service. Much has been and is being achieved to reduce the many problems that have bedeviled our capability and we will continue to work hard to improve our contribution. My thanks go to all members of the QANHS medical dental nursing and support staff officers and ratings. Regular and Reserve and of course our civilian colleagues. I am also personally grateful to my Deputy Director and all the staff of the medical Directorate for their helpful contribution and personal support. My success will reflect a vibrant Service and as I have committed to propose that I will be joining the first commander in the forward-deploy of Surgeon Commander Cox on the 10th October and I wish him well on your Service General.

My principal duty is to welcome our guest Surgeon Cox has been the Deputy Speaker of the House of Lords since 1999. He is the very distinguished daughter of a very distinguished father the former leader of all responses to the crisis who had to know almost every word of the British textbook of surgery in order to pass the Surgical Fellowship. She will tell you more. It is a particularly fitting that Surgeon Cox has agreed to be my guest tonight on the ordinary year of QANHS because she is a nurse and has retained principles of nursing have permeated throughout her life. She did her SEN training at the London

Hospital before training at the Balgownie General Hospital. This was the start of a medical academic progression leading ultimately to being the Chairholder of the University of Manchester. She is now appointed Professor for her research, surgical and personal involvement in the support of under-developed domains and Eastern communities often overseas in Europe, the former Congo wars and most particularly in the Middle East.

Surgeon Cox has spoken extensively on different medical issues in the Upper House on many occasions and has sought to secure a high political recognition for the military medical services. More recently as the debate in the House of Lords on the 2nd of January 2000 instigated by her when Lord Cox warmly congratulated her for her tireless research and every passing opportunity. Indeed the same session that she kindly opened a new Health Studies Division in the Royal Defence Medical College at Fort Monckton in recognition of an establishment when I was the Defence Programme Medical Director. Surgeon Cox your support for the QANHS is greatly appreciated and your presence to come this evening despite your hectic schedule is an immense privilege for us.

The Chief of the Defence Staff has made an outstanding contribution to the Royal Navy throughout a distinguished career. He has commanded the submarine fleet, the Ocean Group and Support and the Royal Fleet. He has been Flag Officer for Training, Flag Officer Surface, Flotilla and Commander Anti Submarine Warfare Standing Force before becoming the Second Sea Lord and Commander in Chief Fleet the First Sea Lord and now of course the Chief of the Defence Staff. I suggest it is unusual for him to attend a Service Dinner without having to speak and so it is an immense pleasure for the Medical Staff to host Admiral Sir Michael Bence this evening. Sir Michael has been a very strong proponent of the RN Medical Service, and the Defence Medical Services. He was the second Sea Lord in the year of 1983-84 when one of the documents was to make the Royal Naval Hospital, Haslemere, into a modern military hospital with a 10 Service complexes. Few people may remember that his commitment was such that he visited every Naval Medical Service Command before the extent of a major ward block at Haslemere, the design and build of the Haslemere Unit to replace the Haslemere Unit was the closure of the Queen Elizabeth Military Hospital, Winchester and the new and

extending Day Surgeon Units for your support for the Naval and Maritime Medical Services is very greatly appreciated.

Other guests include Professor Dame Lesley Seabright, President of the Royal College of General Practitioners, Mrs Sarah McElally, Chief Nursing Officer and Doctor Raj

Sapthomya, Dean of the Faculty of Clinical Dental Practitioners. They and all our guests are most welcome and we welcome your company.

Admiral Jackson proposed the Toast to the Queen and Maritime Coast of Queensland supported.



**Surgeon Captain J A McEl Turner MB ChB FRACP** - New Director of Medical Services

Surgeon Captain Turner is a Consultant Physician at the Royal Queensland Hospital where he has worked since 1983. He specializes in General and Respiratory Medicine.

He is married to Rose and has two children, both currently studying at University.

He joined the Royal Naval Reserve in 1970 and during his career at the RNR Medical Branch he has held the posts of Medical Officer, Regional Training Officer (South West), Medical Support Assistant, Coordinator(R), Deputy Director Medical(R) and has recently been appointed as Director Medical Services.

He is a Knight of the Norwegian Military Order of St John and was appointed as Queen's Honorary Physician in September 2000. His particular interests are in teaching and training of doctors, and postgraduate medical education. He is one of the few physicians qualified to act as instructor in Advanced Training Life Support.

As Director Medical (Reserves) he is responsible for providing education of aspects of RNR medical nursing and medical support specializations, organization, development, recruiting, training and promotion.

## Service News

### Defence Medicine And The NHS – A Developing Partnership

Vicky Wellington

The NHS Human Resources Conference, now in its fourth year, is placed in a prime spot in the NHS annual calendar and was held at the International Conference Centre Birmingham in the beginning of July. The Conference has become the obligatory forum for top professionals who bear the ultimate responsibility for recruiting, training, and retaining NHS staff.

For the third year running, the Surgeon General's Department (SGD) and the National Employers' Liaison Committee (NELC) participated in the Conference. SGDs are currently working as a number of joint ventures with the Department of Health (DH)/NHS, with the aim to enhance the Defence Medical Services (DMS) medical capability and raise awareness of the unique opportunities Defence Medicine has to offer. This year, for the first time, a Conference was:

- The first instance of the DMS
- To present joint MOD/NHS seminars and joint joint ventures
- To promote the benefits to the NHS in facilitating DMS Reserve membership of NHS staff
- To establish lines of communication and network amongst NHS HR Managers

A new proposed health evaluation stand was sponsored by MOD and NELC, displaying the MOD/NHS partnership initiatives, educational films on Service photographs of DMS, presented on deployed operations and facilities, and the Warwickshire Ambulance Service NHS Trust extended medical training for Regular soldiers.

Academic education (Grand Round) included:

- The MOD working with DH to create a powerful partnership
- The MOD and DH in partnership: Caring for our people
- Our commitment: building a working partnership every day

The Band also incorporated special items:

- The Chief Executive of the NHS and Permanent Under Secretary of the DH Nigel Crisp
- The Surgeon General, Lieutenant General Bob Williams
- Deputy Director of NHS Human Resources David Austin
- Chief Executive, University Hospital Birmingham NHS Trust, Mark Bennett

This year a corporate identity was established, implemented by producing corporate business cards and Byron wrote professional encouraging delegates to visit the stand and create a first great show. First year was a short trip to the bathroom to see the DMS in action courtesy of NELC and ED suggested Mafkie soldiers were given to the toilets up. Over 100 delegates, named the conference and website study with the Conference Delegates list, will be used to formulate a number of support NHS HR Managers.

The Conference was an ideal opportunity to explain the role of the DMS and the importance of a strong partnership between military medicine in all its forms, and the NHS.

# Journal of the Royal Naval Medical Service Accounts for the Year ended 30th September 2002

## PROFIT AND LOSS ACCOUNT

	30/9/2002	30/9/2001
<b>Income</b>	<b>£</b>	<b>£</b>
Journal subscriptions	5 900	5 800
Advertising income	114	0
Income received	158	171
Miscellaneous journal sales	171	168
	<u>6 343</u>	<u>6 139</u>
<b>Expenditure</b>		
Printing and distribution costs	5 464	51 778
Postage and stationery	111	208
Banking costs	55	17
Audit and accountancy	118	111
	<u>5 748</u>	<u>52 114</u>
<b>Surplus (Loss) for the Year</b>	<u>695</u>	<u>(47 975)</u>

## BALANCE SHEET

<b>Current Assets</b>	<b>£</b>	<b>£</b>
Investment Accounts	5 748	13 243
Current Accounts	5 921	7 815
	<u>11 669</u>	<u>21 058</u>
<b>Liabilities</b>	<b>£,198</b>	<b>£,804</b>
	<u>614 183</u>	<u>612 612</u>
<b>TOTAL NET ASSETS</b>		
<b>As presented by:</b>		
Balance at 1st October 2001	12 832	15 494
Profit/loss adjustments	1 836	0
Surplus for the Year	695	(47 975)
<b>Balance at 30th September 2002</b>	<u>15 363</u>	<u>(31 481)</u>

## Accountants' Certificate

We have examined the books and records for the year ended 30th September 2002 and checked all the information and explanations considered necessary for the audit. In our opinion the accounts shown above are a fair view of the state of affairs at 30th September 2002 and of the Income and Expenditure for the twelve months period then ended.

Signed: (Name)  
Chartered Certified Accountant

## Administration Notices

### Management Committee

Seagoon Committee (A-J) Ralibuck (Chairman and Editor) Seagoon Capsons (Dr FRB Lock, Seagoon Capsons P J Ralibuck, Commodore P Reed, Wingate Capton, M E Barrow, Capton M Brown QARMS, Seagoon Capson C P O Barker, Commodore D Marshall (Res), Lieutenant Y Mullens (Res)) Dr R J Protheridge is the Editor's editorial address

### Notice to subscribers

A, B, C, Spring and Summer volumes of the Journal of the Royal Naval Medical Service is published each year, one volume comprising three issues. The rates of subscriptions are:

- 1 Serving and retired RN and RNR personnel: members of the Army and Royal Air Force Medical Services: Consultants to the Royal Navy other than MoD or civilian personnel — £12.00 per year plus pmt
- 2 All other categories — £20.00 per year

All communications relating to subscriptions, notifications of change of address etc, should be directed to the Finance and Administration Secretary, JRNMS, Institute of Naval Medicine, Abercrombie Gosport House PO11 2DL.

### Notice to Advertisers

Details of advertising rates and scales of discounts are available from: Green Publications, 20 Masthead Business Park, Soudon Close, Northampton NN4 4AP. e-mail [journal@compulinkcommunications.com](mailto:journal@compulinkcommunications.com)

### Notice to Authors

The Journal of the Royal Naval Medical Service is intended for the publication of original, full and preliminary reports of original research, work by members or invited to the staff of the Service, review and discussion papers of symposia and other reports of naval medicine or as history case reports, media reports. Letters to the Editor, book reviews, Service news including travel and sports reports and education.

All manuscripts should be submitted to the Editor, JRNMS, Masthead House, Institute of Naval Medicine, Abercrombie House PO11 2DL. Each author must sign the covering letter as evidence of consent to publish. One author must be identified and authorized to receive editorial comments and to approve proofs.

Unless specifically stated to the contrary on submissions, papers are accepted on the understanding that they are contributed solely to this journal. Any material previously published should be accompanied by the written consent of the copyright holder to its publication. For illustrations, in tables or acknowledgements should be included in the caption and a full reference provided.

Manuscripts for consideration may be submitted on the following grounds: The Editor retains the copyright right to title and if necessary to disseminate material submitted for publication, to other papers to achieve consistency in nomenclature and to suggest other revisions.

#### Authorship

Authorship credit should be based only on substantial contributions to the concepts and design or analysis and interpretation of data, and in the drafting the text or revising it critically for important intellectual content, and on final approval of the version to be published. Credit may not be used to move all the work. Participation solely in the preparation of funding or collection of data does not justify authorship. If exceptional authors shall produce the data upon which the manuscript is based for examination by the Editor.

### Figures

Preferential use is to take figures, wherever possible, in the form of printed or photographic illustrations (e.g. by making the figures on photographs). Where a picture or figure might be obtained from an illustration or from the text, it is essential that written permission is obtained from the publisher and forwarded with the manuscript. Reports of experiments on human subjects will not be considered unless the protocol was approved by an appropriate ethics committee and followed, and the authors must explicitly state such subjects gave his or her informed consent. Any of the forms of approval according to the ethics committee must be provided.

### Preparation of manuscripts

Manuscripts must be in English or a form suitable for publication in English and presented in **Uppercase Requirements For Manuscript Submitted To Elsevier Journals** (N Engl J Med 1997; 336:12-33) (1) given guidelines. Scientific papers should be prepared with an abstract of the hypothesis, objectives and findings. The should not exceed 100 words. However, unless the text should be used to highlight the content of different sections. Where possible, manuscripts should be prepared in Word 6.0 or in WordPerfect 6.1 and submitted on 3.5 inch floppy disks. Otherwise, they should be prepared in double spacing on one side of A4 paper. The authors should retain a copy of the final manuscript.

### Title page

The title page should contain a concise informative title, spine the key words, the names and initials of all authors and their appointments, and the Department/Institution/Institute/Institution where the work was carried out.

### Tables and illustrations

Tables and illustrations (figures) should add to the paper rather than only repeating information presented in the text. Each table and illustration should be on an individual page separate from the text, be numbered in the first column margins in the order in which they are presented in the text, and have an explanatory caption typed on a separate sheet for discussion.

Three photographs of excellent quality, open on other occasions involving illustration of the Royal Naval Medical Service are required.

Normally printed illustrations will be monochrome. The views of the figures should be simple where colour illustrations are thought to be essential or highly desirable. Photographs must be of good quality, glossy or matt and be provided as contact study films, with captions on a separate sheet. The figure number (author's name and appointment) should be marked on the back. Line drawings should be professionally drawn and labelled, or of equivalent standard and submitted as photographic prints or high quality photocopies. Lettering and numbering should be sufficiently large to ensure legibility when submitted for publication. Photocopying is not acceptable.

### Measurements and abbreviations

Measurements should be given in the units in which they were made but with the exception of blood pressure in mmHg and haemoglobin concentration in g/dl, non metric units must be accompanied by metric (SI) equivalents. The approved units of drugs should be used (generally metric may follow in parentheses) if an alternative unit used, the unit to which a value should be given should be given in full as the first mention in the text, e.g. Volume of Normal Saline (NSM).

### References

Responsibility for the accuracy and completeness of references lies with the author(s) and should not be checked by editorial staff. Only essential references should be included, and authors should verify their accuracy by reference to the original documents. References are classified in the text by superscript letters, numbers, and are numbered and listed consecutively at the end of the manuscript in the order in which they are first cited in the text. A full list of references should be given at the end of the paper using the form of reference adopted by *Lancet* (London). Papers accepted but not yet published should be indicated in the references followed by "in press". Those in preparation (including any submitted for publication, partial communications and unpublished observations) should be referred to as such in the text only.

### Acknowledgments

The assistance of those who are not authors but made substantial contributions to the study and the preparation of the paper should be acknowledged in the Acknowledgments section, giving names, degrees, degrees and







The first part of the paper discusses the importance of understanding the underlying mechanisms of the observed phenomena. This is followed by a detailed analysis of the data, which reveals several key findings. The results indicate that the proposed model is highly effective in capturing the essential features of the system under study. Furthermore, the analysis shows that the system exhibits a high degree of robustness and adaptability to various external factors. These findings have significant implications for the design and implementation of related systems. The paper concludes by summarizing the main results and highlighting the potential for future research in this area.

The second part of the paper focuses on the practical application of the theoretical findings. It describes the development of a prototype system that implements the proposed model. The system is designed to be user-friendly and efficient, allowing for easy integration into existing workflows. The results of the initial testing phase are presented, showing that the system performs well under various conditions. The paper also discusses the challenges encountered during the development process and offers suggestions for addressing them. Finally, the paper provides a comprehensive overview of the system's capabilities and its potential impact on the field.

The third part of the paper discusses the broader context of the research and its relevance to the current state of the field. It compares the findings of this study with those of previous research, highlighting the contributions of the current work. The paper also discusses the limitations of the study and the need for further research to address these limitations. Finally, the paper provides a summary of the key points and a call to action for the research community to continue exploring this important area of study.

the 'information' and 'communication' fields, and the 'information science' field.

It is important to note that the 'information science' field is not a sub-field of the 'information' field, but a separate field, as shown in Figure 1.

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